

1. DECEASED-NAME (Type or print) First Middle Last FRANK W. ABERNATHY			2a. DATE OF DEATH Month Day Year JUNE 23 1969			2b. HOUR 1:55 PM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH Jan. 1 1892		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) KY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RET.-U.S. GOVT. OWNER-OPERATOR - LODGE			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE VIRGINIA			13b. COUNTY ALEXANDRIA			13c. STREET AND NUMBER 2905 BOSWELL AVE.				
14. FATHER'S NAME First Middle Last JOHN B. WATHEN			15. MOTHER'S MAIDEN NAME First Middle Last FANNY T. Russell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 579-46-5009A			17. INFORMANT H. L. GAST - Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, old and acute 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary thrombosis, old and recent DUE TO, OR AS A CONSEQUENCE OF (c) Advanced coronary arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral infarctions, old, left basal ganglia due to arteriosclerosis.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If injury, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from June 19 57, to June 23 1969, that (I) (we) last saw the deceased alive on June 22 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michel M. Healy MD						22c. DATE SIGNED 6/23/69				
22d. PHYSICIAN'S NAME (Type) MICHEL M. HEALY (M.D.)						22e. ADDRESS 5411 W. Cedar La, Bethesda, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 6/25/69		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION (City or Town) (County) (State) SILVER SPRING, MD.			
24. FUNERAL DIRECTOR JOSEPH CAWLER'S SONS, 5130 WILKENSIN AVE. WASHINGTON, D.C.						25a. REC'D BY REGISTRAR JUN 26 1969		25b. REGISTRAR'S SIGNATURE Charles Young		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) LISA			First RENEE Middle ALLEN Last			2a. DATE OF DEATH JUNE Month 12 Day 69 Year			2b. HOUR 3:00 PM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 12 JUNE 1969			6. AGE (In years last birthday) — YRS.		IF UNDER 1 YEAR MONTHS — DAYS —	IF UNDER 24 HRS. HOURS 8 MIN 15
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY			Md.
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND			13b. COUNTY PR. GEORGES		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER APT 127 8106 GORMAN AVE	
14. FATHER'S NAME First JOHNNIE Middle D Last ALLEN			15. MOTHER'S MAIDEN NAME First TOBY Middle ANN Last McCABE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT Address APT 127 8106 GORMAN, LAUREL, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral atelectases 7769 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that AK (this hospital) attended the deceased from JUNE 12 , 19 69 , to 12 JUNE , 19 69 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 12 JUNE 1969 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Gary H. Safley					22c. DATE SIGNED 13 June 1969			22d. PHYSICIAN'S NAME (Type) Gary H. Safley, M.D.		
22e. ADDRESS Naval Hospital, Bethesda Md.										
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE JUNE 16, 1969		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.			
24. FUNERAL DIRECTOR Takoma Funeral Home ADDRESS 254 Carroll St., Takoma Park, Maryland					25a. REC'D BY REGISTRAR JUN 16 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08501

CERTIFICATE OF DEATH

08495

1. DECEASED-NAME (Type or print) Perry Bartholow Allen			2a. DATE OF DEATH Month June Day 23 Year 1969			2b. HOUR 12:45 A. M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH October 25, 1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Printer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7804 Carroll Avenue	
14. FATHER'S NAME First Thomas Middle E. Last Allen			15. MOTHER'S MAIDEN NAME First Mae (May) Middle Meford Last Meford						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 579-09-5010A		17. INFORMANT QA Patient's chart		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobular DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic heart disease, mitral stenosis DUE TO, OR AS A CONSEQUENCE OF (c) and myocardial congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days Known for years-									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 12, 1969 , to June 23, 1969 , that (I) (we) last saw the deceased alive on June 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Aaron H. Traum M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Aaron H. Traum, M.D.		22e. ADDRESS 8237 Georgia Ave. Silver Spring, Maryland		22c. DATE SIGNED June 25, 1969					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/27/69		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.			
24. FUNERAL DIRECTOR The S. H. Hines Company				ADDRESS Washington, DC		25a. REC'D BY REGISTRAR JUN 27 1969		25b. REGISTRAR'S SIGNATURE William S. Under	



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U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08502

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08496

1. DECEASED-NAME (Type or Print) <i>William Prescott Allen</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>June 8 1969</i>			2b. HOUR <i>1:00 P.M.</i>		
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>Jan. 24 1904</i>	6. AGE (In years last birthday) <i>65</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>June</i> Day <i>8</i> Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>Georgia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>EDITOR - NEWSPAPER</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>Mont. Co.</i>		13c. CITY OR TOWN <i>Beth.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8020 - Hampden Lane</i>
14. FATHER'S NAME First <i>Westley</i> Middle <i>C.</i> Last <i>Allen</i>			15. MOTHER'S MAIDEN NAME First <i>Fda</i> Middle <i>5</i> Last <i>Prescott</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16b. SOCIAL SECURITY NO. <i>579-09-43</i>			17. INFORMANT <i>Paul Luther Mather Jr.</i>			ADDRESS <i>9915 - Bethesda, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis, acute</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>left coronary Coronary thrombosis, acute, descending branch</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4109</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Jan 9, 1969</i>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify) <i>XXXX</i>			23b. DATE <i>6-11-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Md.</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> ADDRESS <i>7557-Wisconsin Ave., Bethesda, Md.</i>					25a. REC'D BY REGISTRAR <i>JUN 16 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

08203



1959

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First IMA			Middle JEWEL			Last AUGUSTAT		
3. SEX FEMALE			4. RACE CAUCASIAN			5. DATE OF BIRTH JANUARY 22, 1918			2a. DATE OF DEATH Month JUNE Day 17 Year 1969		
7a. BIRTHPLACE (State or foreign country) TEXAS			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Rockville			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1001 Rockville pike, Apt. 1311		
14. FATHER'S NAME First Allen Middle Simmons Last Simmons			15. MOTHER'S MAIDEN NAME First Eula Middle Maude Last Perry			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO.		
17. INFORMANT (Husband) Theodore J. AUGUSTAT, Apt. #1311, Rockville, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anaplastic Sarcoma of Chest wall with Metastases</u> 1959 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>May 10</u> , 19 <u>69</u> , to <u>June 17</u> , 19 <u>69</u> , that <u>XX</u> (we) last saw the deceased alive on <u>June 17</u> , 19 <u>69</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>XX</u> (we) (did) <u>not</u> view the body after death.											
22b. SIGNATURE <u>A. A. Musca</u>						22c. DATE SIGNED 17 June 1969					
22d. PHYSICIAN'S NAME (Type) <u>A. A. MUSCA, LCDR MC USNR</u>						22e. ADDRESS Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, or other disposal (Specify) Burial			23b. DATE June 21-69			23c. NAME OF CEMETERY OR CREMATORY AUSTIN MEMORIAL PARK			23d. LOCATION (City or Town) (County) (State) AUSTIN TEXAS		
24. FUNERAL DIRECTOR <u>R. A. PUMPHREY</u> ADDRESS 7557 Wisconsin Ave., Bethesda, Md.						25a. REC'D BY REGISTRAR DATE JUN 23 1969			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

BOARD

DEPARTMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08504

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08498

1 DECEASED NAME (Type or print) EVA LOY BARCUS			2a DATE OF DEATH Month June Day 18 , Year 1969			2b HOUR 11⁰⁰ P. M.	
3. SEX Female		4 RACE Cauc.		5. DATE OF BIRTH Feb. 2, 1883		6. AGE (In years last birthday) 86 YRS	
7a BIRTHPLACE (State or foreign country) IOWA		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Rockville, XXXX		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8 Orchard Way		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 8 Orchard Way							
14. FATHER'S NAME First Middle Last William Hammond			15 MOTHER'S MAIDEN NAME First Middle Last Matilda Ping				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) No		16b SOCIAL SECURITY NO 455-09-4199		17 INFORMANT Daughter		Address Same as Item 13.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive Heart failure 4/12/1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive, atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs Undetermined							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus.							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 6/10/1969 to 6/16/1969 , that (I) (we) last saw the deceased alive on 6/16/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Faruk Ozer		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 6/16/69			
22d PHYSICIAN'S NAME (Type) FARUK OZER		22e ADDRESS 1125 Rockville Pike Rockville, Md					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 6-19-69		23c NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d LOCATION (City or Town) (County) (State) Rockville, Maryland	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a REC'D BY REGISTRAR JUN 23 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2a Film 414
7-14-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08505

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08499

1. DECEASED NAME (Type or Print) First Middle Last <u>GEORGE B. BARIANOS</u>			2a. DATE KNOWN OF DEATH Month Day Year <u>JUNE 29 1969</u>			2b. HOUR 12 P M	
3. SEX <u>MALE</u>	4. RACE <u>WHITE</u>	5. DATE OF BIRTH <u>2/8/37</u>	6. AGE (In years last birthday) <u>32 YRS</u>	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <u>32 YRS</u>	8. F UNDER 24 HRS <u>32 YRS</u>	2c. DATE PRONOUNCED DEAD Month Day Year <u>JUNE 29 1969</u>	
7a. BIRTHPLACE (State or foreign country) <u>GREECE</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u>	
10. CITY OR TOWN OF DEATH <u>BETHESDA</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>SUBURBAN</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>RESTAURANT</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>Wheaton</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <u>WILLIAM JOHN BARIANOS</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>THEODORA W. BARIANOS</u>		17. INFORMANT ADDRESS <u>Mrs. Herlenda Barianos 3913 Minden Rd. Wheaton</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT ADDRESS <u>Mrs. Herlenda Barianos 3913 Minden Rd. Wheaton</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thrombosis, superior & inferior vena cava</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>phlebitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>burns, 2nd, and 3rd, degree</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>51 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOURS MIN <u>2:00 PM 5/10 1969</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Driving rug with gasoline & exploded</u>			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>RESTAURANT</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>Georgetown Rd. Bethesda Montgomery Md.</u>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>John G. Ball, M.D. Rd., Beth., Md.</u>				22b. DATE SIGNED <u>June 30, 1969</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 2, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc., 8434 Ga., Ave., S.S.</u>				25a. REC'D BY REG STRAR <u>MAJL 7 1969</u>		25b. REG STRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08506		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08500	
1. DECEASED-NAME (Type or print) Lawrence M. Barrett					2a. DATE OF DEATH Month 6 - Day 21 - Year 69		2b. HOUR 3:40 A.M.
3 SEX Male	4 RACE White	5 DATE OF BIRTH 11-6-92		6 AGE (In years last birthday) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Pa.	7b CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Suburban		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY Engineer	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Potomac	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 11309 Gainsborough Rd.	
14 FATHER'S NAME First Middle Last Thomas Barrett		15. MOTHER'S MAIDEN NAME First Middle Last Alice MacCallister		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			
16b SOCIAL SECURITY NO. 203-05-3505		17 INFORMANT Address Alice Francis 11309 Gainsborough Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia due to urinary tract infection 577.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Recent Fracture (R) Hip.							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from May 10 , 19 67 , to June 1 , 19 67 , that (I) (we) lost saw the deceased alive on June 10 , 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Stacy J. Cohen M.D.				22c DATE SIGNED 6/21/67			
22d PHYSICIAN'S NAME (Type) Stacy J. Cohen, M.D.				22e ADDRESS 5000 Rockville Pike, Arlington, Va.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 6/24/69		23c NAME OF CEMETERY OR CREMATORY Columbia Gardens		23d LOCATION (City or Town) (County) (State) Arlington, Virginia	
24 FUNERAL DIRECTOR 1331 Rockville Pike Tyson Wheeler Funeral Home, Rockville, Md				25a REC'D BY REGISTRAR JUN 25 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

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08507

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08501

1 DECEASED NAME (Type or print) VICTOR		First Middle Last A. BARTLETT, JR		2a. DATE OF DEATH Month Day Year 6 4 69			2b. HOUR 10^{PM}				
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 10-26-93		6. AGE (In years last birthday) 75 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			Md		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4700 ROSEDALE AVE BETHESDA, MD.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Civil. Assist. to		12b. KIND OF BUSINESS OR INDUSTRY U.S.C.G.					
3a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13a. COUNTY MONTGOMERY		13b. CITY OR TOWN BETHESDA		13c. INS DE CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4700 ROSEDALE AVE		Hqts. Attendant.	
14. FATHER'S NAME First Middle Last Charles Bartlett		15. MOTHER'S MAIDEN NAME First Middle Last Lena Rhodes									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16b. SOCIAL SECURITY NO 217-36-5327		17 INFORMANT Wife:		Address Mrs. Faye R. Bartlett, As Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 4109 DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE YES. DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY EDEMA MONTHS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb. 4, 1964 to 6/4, 1969 , that (I) (we) last saw the deceased alive on 6/4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michel M. Healy MD		22c. DATE SIGNED 6/5/69		22d. PHYSICIAN'S NAME (Type) MICHEL M. HEALY, M.D.		22e. ADDRESS 5411 Cedar Lake, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-6-69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Pr. Geo. Co. Md					
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.		7557 Wisconsin Ave.		25a. REC'D BY REGISTRAR JUN 9 1969		25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First WILLIAM			Middle HENRY			Last BATES		
2a. DATE OF DEATH			Month JUNE			Day 22			Year 1969		
2b. HOUR			0800			A.M.					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 26 APR 17		6. AGE (In years lost birthday)		F UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS	
7a. BIRTHPLACE (State or foreign country) MASS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give full address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during life, even if retired) CONGRESSMAN			12b. KIND OF BUSINESS OR INDUSTRY US GOVERNMENT		
13a. USUAL RESIDENCE (Where deceased admission) STATE MASS			13b. CITY OR TOWN SALEM			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER 35 WARREN ST.		
14. FATHER'S NAME First GEORGE			Middle J.			Last BATES			15. MOTHER'S MAIDEN NAME First NORA		
Middle UNK			Last JENNINGS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO 035-12-4376			17. INFORMANT Address MRS. PEARLE BATES 1710 HOLLY ST. N.W., WDC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (H) (this hospital) attended the deceased from March 13, 1969 , to June 22, 1969 , that (H) (we) last saw the deceased alive on June 22, 1969 , and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>L. Raymond</i>						DEGREE LCDR, MC, USN		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 22 JUN 69	
22d. PHYSICIAN'S NAME (Type) L. RAYMOND, LCDR, MC, USN						22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.					
23a. BURIAL REMOVAL (Specify)		23b. DATE 6/26/69		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY		23d. LOCATION (City or Town)		(County)		(State) MASS	
24. FUNERAL DIRECTOR <i>Joseph Gawler</i>						25a. REC'D BY REGISTRAR DATE JUN 26 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08509

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08503

1 DECEASED-NAME (Type or Print) <i>Willie Lee Battle Jr.</i>			2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> 6.30 1969			2b HOUR 3:20 PM			
3 SEX <i>male</i>	4 RACE <i>Negro</i>	5 DATE OF BIRTH <i>10/28/41</i>	6 AGE (In years last birthday) <i>27</i> YRS	IF UNDER 1 YEAR MONTHS	DAYS	F UNDER 24 HRS HOURS	MIN.	2c DATE PRONOUNCED DEAD Month <i>June</i> Day <i>30</i> Year <i>1969</i>	2d HOUR <i>3:24</i> PM
7a BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>			2e HOUR
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.)			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, 1 institution on. Residence before admission) STATE <i>Maryland</i>			13b COUNTY <i>Montgomery</i>			13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>Willie</i> Middle <i>Lee</i> Last <i>Battle Sr.</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>?</i> Last <i>?</i>			13e. STREET AND NUMBER <i>714 LENMORE AVE</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>			16b SOCIAL SECURITY NO			17. INFORMANT ADDRESS <i>Ida Mae Battle - wye - Qdd. some</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Laceration of brain, severe</i>									<i>sudden</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Trauma from a motorcycle accident</i>									<i>sudden</i>
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year <i>3:20 PM 6/30 1969</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <i>Lost control of his motorcycle he was driving</i>				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory office building, etc.) <i>Highway</i>		21f LOCATION Street or R.F.D. No <i>Route 28</i>		City or Town <i>Gaithersburg</i>		County <i>Montgomery</i>	State <i>Md</i>
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John B. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>June 30, 1969</i>			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county)						
23a BURIAL (CREMATION REMOVAL) (Specify) <i>BURIAL</i>		23b DATE <i>7/3/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Lincoln Park Cem.</i>		23d LOCATION (City or Town) <i>Rockville</i>		(County) <i>Montg.</i>	(State) <i>Md</i>
24 FUNERAL DIRECTOR <i>Robert L. Susowden</i>			ADDRESS <i>Rockville, Md.</i>			25a REC'D BY REGISTRAR <i>JUL 7 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

FOR STATE
HEALTH DEPT.

Items 18-22a Film 415 MARYLAND STATE DEPARTMENT OF HEALTH
8-8-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08510

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08504

1. DECEASED NAME (Type or Print) Aurusta Katharine		First Middle Last		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 27 Year 1969		2b. HOUR 2:25 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 2-24-22	6. AGE (in years last birthday) 91 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 6 Day 27 Year 1969
7a. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery
10. CITY OR TOWN OF DEATH Beltsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Beltsville Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk-Engraving		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN WASH.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 411 1/2 Prince Georges Pkwy
14. FATHER'S NAME John Bittershofer		First Middle Last		15. MOTHER'S MAIDEN NAME Christine Watenhagen		First Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO 579-60-7028		17. INFORMANT 805-B Hamilton Street XXXXXXXXXXXX Virginia Hoy-Dan Richmond, Va		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive subdural hematoma, left cerebral hemisphere DUE TO, OR AS A CONSEQUENCE OF (b) left cerebral hemisphere DUE TO, OR AS A CONSEQUENCE OF (c) left cerebral hemisphere Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 6:00 PM 6-26 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased fell at home		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc) Home		21f. LOCATION Street or RFD No 7611 Ga. Ave. N.W. City or Town Washington County D.C. State D.C.		
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED June 27, 1969
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/30/1969		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		C. Glen Carter ADDRESS Sil. Spg, Md		25a. REC'D BY REGISTRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE William J. Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-10-69. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

450X

08511

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08505

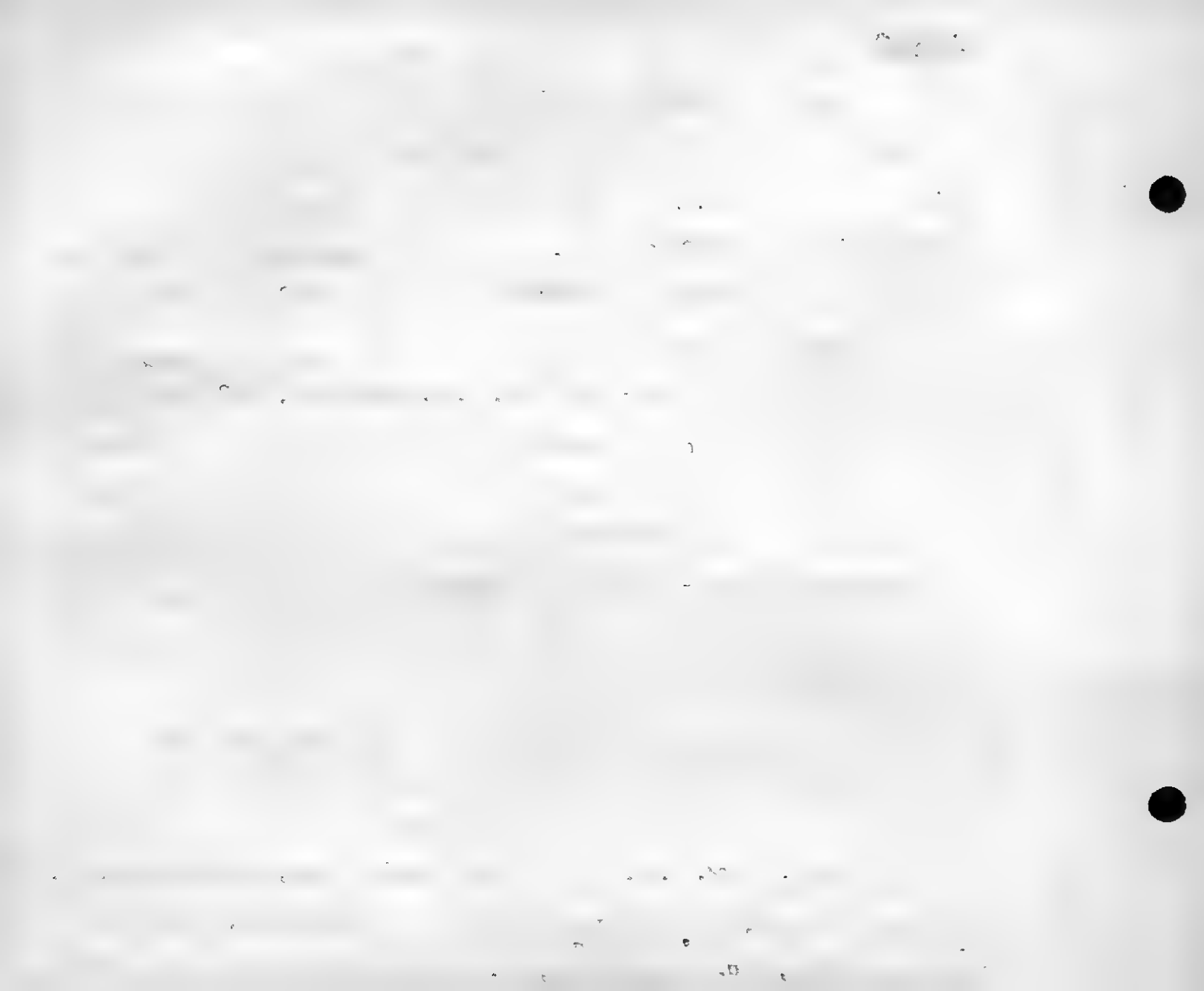
1 DECEASED NAME (Type or print) EDITH First M. Middle BERRY Last			2a DATE OF DEATH Month 6 Day 12 Year 69		2b HOUR 12:20
3 SEX female	4 RACE white	5 DATE OF BIRTH 12/6/82		6 AGE (In years last birthday) 86 YRS.	7 UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) Mich.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Silver Spring		13c STREET AND NUMBER 2133 Bucknell Terrace	
14 FATHER'S NAME First Elind Middle J. Last Knapp		15 MOTHER'S MAIDEN NAME First Jeanette Middle Northway Last Northway		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	
16b SOCIAL SECURITY NO 375-18-4662A		17 INFORMANT Austin Berry (Son)		Address Silver Spring, Md.	
18 CAUSE OF DEATH (Enter only one cause per line - (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 450X					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Active pulm. Arteriosclerotic Cardiovascular disease, Tuberculosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 15, 1969 to June 12, 1969 , that (I) (we) lost the deceased alive on 6/12/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.					
22b. SIGNATURE Myron L. Lenkin		22c. DATE SIGNED 6/12/69		22d. PHYSICIAN'S NAME (Type) Myron L. Lenkin	
22e. ADDRESS 2309 Shorefield Rd., Wheaton, Md.		23a. BLURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 16, 1969	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City or Town) (county) (State) Grand Rapids, Michigan		24. FUNERAL DIRECTOR Warner L. Humphrey, Inc., Silver Spring, Md.	
25a. REC'D BY REGISTRAR JUN 18 1969		25b. REGISTRAR'S SIGNATURE William Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

410

08512		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08506	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print) Maude Katherine Bishop			2a. DATE OF DEATH Month June Day 23 Year 1969			2b. HOUR 7:05 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 17, 1884		6. AGE (In years last birthday) 85 YRS.	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2902 Radins Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Dress Maker	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2902 Radins Road	
14. FATHER'S NAME First Frederick Middle Elnor Last			15. MOTHER'S MAIDEN NAME First Mary Middle Last Martin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 577-01-7774		17. INFORMANT Silver Spring, Md. Mrs. J. D. Stephenson, 2902 Radins Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis						sudden 4 months years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) carcinoma of bowel - 15 years ago (surgery)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 23, 1969 , to June 23, 1969 , that (I) (we) last saw the deceased alive on June 23, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Philip E. Jones M.D.				22c. DATE SIGNED 6/24/69			
22d. PHYSICIAN'S NAME (Type) Philip E. Jones, M.D.				22e. ADDRESS 800 Pershing Drive, Silver Spring, Md.			
23a. BURIAL (CREMATION, REMOVAL) (Specify) Cremation		23b. DATE June 26, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR'S NAME (Type) Warner E. Humphrey, Inc.				25a. REC'D BY REGISTRAR JUN 27 1969		25b. REGISTRAR'S SIGNATURE Richard J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08513

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08507

1 DECEASED-NAME (Type or print) Kate First A. Middle Bonwit Last			2a. DATE OF DEATH Month 6 Day 8 Year 69			2b. HOUR 8:15 A.M.	
3 SEX F		4 RACE W		5 DATE OF BIRTH 5/8/91		6 AGE (In years last birthday) 78 YRS	
7a BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Wheaton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Hills Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Typist in Govt.		12b. KIND OF BUSINESS OR INDUSTRY U.S.	
13a. USCLA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2101 16th St.		14 FATHER'S NAME First Simon Middle Adler Last Adler(?)		15 MOTHER'S MAIDEN NAME First Frances Middle Adler(?) Last Adler(?)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>		16b. SOCIAL SECURITY NO 117-07-0228		17. Bonwit - 401 1/2 Adams Ave. S.E. Wash. D.C. Adler - 12915 Flak Rd. Wheaton			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjunctive Heart Failure DUE TO, OR AS A CONSEQUENCE OF ASCD. Hypothyroidism years (b) Pneumonia, Paged 12 years DUE TO, OR AS A CONSEQUENCE OF years (c) years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 5/30, 1967 , to 6/8/67 , that (X) (we) lost saw the deceased alive on June 8, 1967 , and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE N. Shah, M.D.		22c. DATE SIGNED 6/8/67		22d. PHYSICIAN'S NAME (Type) N. SHAH, MD		22e. ADDRESS 2121 Penn Ave, NW, Wash DC	
23a. BURIAL, CREMATION REMOVAL (Specify) CREMATION		23b. DATE 6-10-69		23c. NAME OF CEMETERY OR CHAPEL CEDAR HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) WASHINGTON DC	
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS - WASH. D.C.		25a. REC'D BY REGISTRAR JUN 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08514

MARTYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08508

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
Alfred		Bertram		Boenstein	6 5 69		10 ⁴⁵ P M	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
m.	W.		5/19/16		53 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
New York		U.S.				Montgomery Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring Md.		Howe Hospital, Forest Glen				INTERPRETER		
13a USUAL RESIDENCE (Where deceased lived, admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER
Md.		Montgomery		Silver Sp.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9501 Brunett H.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
William				Bornstein	Kate			Smith
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No		188-10-4396		Mrs. Ethel Bornstein		9501 Brunett Ave. Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>								5 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary arteriosclerosis - calcific - severe</u>								Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
<u>Diabetes mellitus</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>50</u> , to <u>June 5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED
Aaron H. Traum		MD		<input checked="" type="checkbox"/>				June 6, 1969
22d PHYSICIAN'S NAME (Type)		22e ADDRESS		22f REGISTRAR'S SIGNATURE				
		8237 Georgia Ave Silver Spring Maryland						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		June 8, 1969		King David Memorial Garden Falls Church, Virginia				
24 FUNERAL DIRECTOR		24b ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Donald M. Stein		232 Carroll St., N.W. Wash., D.C.		JUN 10 1969		Charles Judge		



20-110

398X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08515

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08509

1 DECEASED-NAME (Type or print) Anna M Bower			2a. DATE OF DEATH Month JUNE Day 16 Year 1969			2b. HOUR 12:50 PM				
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 9/7/95		6 AGE (In years last birthday) 73 7/8 YRS.		IF UNDER 1 YEAR MONTHS 13 DAYS 7 HOURS 8 MIN		
7a. BIRTHPLACE (State or foreign country) MICH.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md				
10 CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2423 Homestead Drive	
14 FATHER'S NAME First Anthony Middle Stechman Last Gertrude			15 MOTHER'S MAIDEN NAME First Gertrude Middle Jansen Last Jansen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 218-50-6613		17 INFORMANT Clyde B. Bower Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Calcific aortic stenosis with insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Probable rheumatic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) ASHD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from approx 1965 , to June 16, 1969 , that (I) (we) last saw the deceased alive on June 14, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.										
22b. SIGNATURE Gene U. Cohen, M.D.						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 16, 1969		
22d. PHYSICIAN'S NAME (Type) GENE U. COHEN, M.D.						22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MARYLAND 20910				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE June 19, 1969		23c. NAME OF CEMETERY OR CREMATORY Parklawn			23d. LOCATION (City or Town) (County) (State) Rockville Maryland		
24 FUNERAL DIRECTOR Francis J. Collins						ADDRESS 500 Univ Blvd. Sil Spr Md		25a. REC'D BY REGISTRAR JUN 23 1969		
25b. REGISTRAR'S SIGNATURE Francis J. Collins										

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08516

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08510

1 DECEASED NAME (Type or Print) TROY DECKER BOWSER			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 10 Year 1969			2b HOUR 1:15 M		
3 SEX MALE	4 RACE W	5 DATE OF BIRTH 5-15-47	6 AGE (In years last birthday) 22 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	7 UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month June Day 10 Year 1969		
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Bethesda.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 495+270 Highway Bethesda		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 2525 WENDOVER RD.
14. FATHER'S NAME First IVAN Middle E Last BOWSER			15 MOTHER'S MAIDEN NAME First UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		(If yes give war or dates of service) ACTIVE		16b SOCIAL SECURITY NO 212-48-9112		17 INFORMANT IVAN E. BOWSER 2525 WENDOVER RD BALTIMORE, MD		
18 CAUSE OF DEATH (Enter on only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries Severe 316.1 DUE TO, OR AS A CONSEQUENCE OF (b) Trauma from Auto Accident. DUE TO, OR AS A CONSEQUENCE OF (c) last. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 10 AM 6-10-1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Passenger in Auto that went out of control.				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway.		21f LOCATION Street or RFD No. City or Town County State 495+270-Highway Bethesda Montgomery Md				
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Ball		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED June 10, 1969
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 6-14-69		23c NAME OF CEMETERY OR CREMATORY DULANEY VALLEY MEA GARDEN		23d LOCATION (City or Town) (County) (State) BALTIMORE, MD		
24 FUNERAL DIRECTOR W W CHAMBERS CO 1400 CHAPIN ST. N.W. WASH. D.C.				25a REC'D BY REGISTRAR JUN 16 1969		25b REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

08517										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08511																																							
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
Charles B. Branzell										June 11 Year 69										405 M																																							
3. SEX Male										4. RACE White										5. DATE OF BIRTH Jan. 1 1887										6. AGE (In years last birthday) 82 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN										IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Dist of Columbia										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery Md																													
10. CITY OR TOWN OF DEATH Bethesda										11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital) 8108 MacArthur Blvd.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) conductor										12b. KIND OF BUSINESS OR INDUSTRY Transit Co																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. CITY OR TOWN Montgomery										13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 8108 MacArthur Blvd.																													
14. FATHER'S NAME Samuel										15. MOTHER'S MAIDEN NAME Mary Louise Jones																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or (unknown) No										16b. SOCIAL SECURITY NO. 578 10 6626										17. INFORMANT Susie Irene Branzell										Address Wife #13																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> <u>185X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PRIMARY CARCINOMA of PROSTATE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> <u>6 MONTHS</u>																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>59</u> , to <u>JUNE</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>JUNE 9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE <u>[Signature]</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>6/11/69</u>																																							
22d. PHYSICIAN'S NAME (Type) <u>DR. LEO J. DONOVAN</u>										22e. ADDRESS <u>FAIR WISCONSIN AVE BETHESDA</u>																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 14 June 69										23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.										23d. LOCATION (City or Town) (County) (State) Silver Spring Mont. Md.																													
24. FUNERAL DIRECTOR <u>Robert A. DeVol</u>										Address Washington DC										25a. REC'D BY REGISTRAR JUN 16 1969										25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08518		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08512	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
ARTIE		CHRISTINA	BROADHURST		9-22-69		8 A M
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	7 IF UNDER 1 YEAR	
FEMALE	WHITE		7-24-81		87 YRS	MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
MARYLAND	U.S.A.				MONTGOMERY Md		
1d CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
BETHESDA		9919 OLD GLOUGETOWN RD.		HOUSEWIFE		HOME	
13a USUAL RESIDENCE (Where deceased lived, if institution Res. before admnssion) STATE		13b COUNTY		13c CITY OR TOWN	3d INSIDE CITY, HTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER	
MARYLAND		MONTGOMERY		BETHESDA		9919 OLD GLOUGETOWN RD.	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		
JOHN			HAGER		MILLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give way or dates of service)		16b SOCIAL SECURITY NO		17. INFORMANT		Address	
NO				Daughter		BETHESDA, MARYLAND	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary Insufficiency Acute					
4114		DUE TO, OR AS A CONSEQUENCE OF					
Conditions (any which gave rise to immediate cause (a), stating the underlying cause lost)		Rheumatic Heart Disease					
		DUE TO, OR AS A CONSEQUENCE OF					
		Generalized Arterio-Sclerosis					
		years.					
		years.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		HOUR A.M. Month Day Year P.M. 19					
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)		21f LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work				Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1946 to Date 19, that (I) (we) last saw the deceased alive on June 16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b SIGNATURE		22c DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d DATE SIGNED	
John G. Ball M.D.		M.D.				June 22, 1969	
22d PHYSICIAN'S NAME (Type)		22e ADDRESS		22f REGISTRAR'S SIGNATURE			
JOHN G. BALL, M.D.		7557 WISCONSIN AVE		BETHESDA, MARYLAND			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
BURIAL		6-25-69		BROWNSVILLE METHODIST BROWNSVILLE		MARYLAND	
24. FUNERAL DIRECTOR		7557 WISCONSIN AVE		REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY, BETHESDA, MARYLAND				JUN 24 1969		John G. Ball	

08519

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 5&6 Film 414 7/1/69 kk

CERTIFICATE OF DEATH

08513

1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
RUFUS			GORDON			BROOKS			June 16 1969 1:38 AM		
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS	
Male		White		May 20, 1896		73 1/4 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED			9. COUNTY OF DEATH		
			AMERICA			NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington Saut Hosp.			Carpenter					
13a. USUAL RESIDENCE (Where deceased lived 1 month before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Adelphi			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
									1800 Keokee ST.		
14 FATHER'S NAME			5 MOTHER'S MAIDEN NAME			15. ADDRESS					
George			Brooks			Mary			Wilson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT					
NO			578-12-1785			Pis. Chart					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anterograde Conduction Defect</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>with Congestive Heart Failure</u>											
(b) <u>Myocardial Fibrosis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			yes		
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION			21g. LOCATION		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No.			City or Town		
						County			State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 19 68</u> to <u>June 19 69</u> , that (I) (we) lost saw the deceased alive on <u>June 15 19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE											
Boris RABKIN - DEGREE											
ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>											
22c. DATE SIGNED											
6-16-69											
22d. PHYSICIAN'S NAME (Type)											
BORIS RABKIN, MD											
22e. ADDRESS											
1019 Union Blvd, East River Springs											
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			June 18, 1969			Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR											
F. Gasch's Sons Hyattsville, Md.											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											
JUN 19 1969											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1533

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) William		First J.		Middle J.		Last BROOKS		2a. DATE OF DEATH Month 6 Day 5 Year 69		2b. HOUR 9:45 M	
3. SEX M		4 RACE N		5. DATE OF BIRTH 5-1-08				6 AGE (in years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS 1 DAYS 11	
7a BIRTHPLACE (State or foreign country) Md		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY					
10 CITY OR TOWN OF DEATH SPRINGFIELD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BEL-PRE HEALTH CENTER				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) W.S.S.C.				12b KIND OF BUSINESS OR INDUSTRY Ad Govt.	
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY PG.		13c CITY OR TOWN FAIRMONT Hts.		3d INSIDE CITY <input type="checkbox"/> OUTSIDE <input type="checkbox"/>		13e STREET AND NUMBER 1002 - 60th AVE			
14 FATHER'S NAME First William J. Middle Brooks Last Brooks				15 MOTHER'S M maiden NAME First Lois Middle Green Last Green							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b SOCIAL SECURITY NO. 215 260 207		17 INFORMANT Thelma O Brooks				Address 1002-60th Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute pulmonary insufficiency											
DUE TO, OR AS A CONSEQUENCE OF (b) metastatic carcinoma of the sigmoid colon											
DUE TO, OR AS A CONSEQUENCE OF (c) chronic anemia											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) metastatic card tumor with complete blockage											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from 4/24 , 19 69 , to 6-5 , 19 69 , that (I) (we) last saw the deceased alive on 5-19-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Rafael C. Incline				DEGREE PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c DATE SIGNED June 5, 1969			
22d PHYSICIAN'S NAME (Type) RAFAEL C. INCLIN				22e ADDRESS 3505 Dorlag Park Road, Gaithersburg							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 6-11-69		23c NAME OF CEMETERY OR CREMATORY Baltimore Nat		23d LOCATION (City or Town) Croftsville		(County) Md		(State)	
24 FUNERAL DIRECTOR R.S. Worthington & Mrs Derrave				ADDRESS 4925				25a REC'D BY REGISTRAR JUN 12 1969		25b REGISTRAR'S SIGNATURE James J. Judge	



4124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08521

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08515

1. DECEASED NAME (Type or print) <i>Louise</i>			First Middle Last <i>F Bugh</i>			2a. DATE OF DEATH Month Day Year <i>JUNE 6 1969</i>			2b. HOUR <i>6:40 P.M.</i>		
3. SEX <i>F</i>			4. RACE <i>W</i>			5. DATE OF BIRTH <i>Feb. 7, 1888</i>			6. AGE (In years lost birthday) <i>81</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>New York</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery County</i> Md		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Adelphi</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>12001 Mezzero Road</i>			14. FATHER'S NAME First Middle Last <i>George Hahn</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Katherine Bender</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No</i> (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO. <i>094 18 6776</i>			17. INFORMANT <i>Mrs. Catherine Tocha</i>			319 E. Plymouth Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes Mellitus</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State <i>Jan 65 June 6-69</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 65</i> , 19 <i>65</i> , to <i>June 6-69</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>June 6 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Bernard A. Fitzgerald</i> M.D.						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>6-6-69</i>		
22d. PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>						22e. ADDRESS <i>217 Univ. Blvd E, Silver Spring Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>June 10, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Buffalo N. Y. Erie N. Y.</i>		
24. FUNERAL DIRECTOR <i>Francis J. Collins</i>						ADDRESS <i>500 University Blvd N. Silver Spring Md</i>			25a. REC'D BY REGISTRAR DATE <i>JUN 10 1969</i>		
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



Item 2a Film 415
8/4/69kk

08522 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08516

FOR STATE HEALTH DEPT.

1. DECEASED-NAME (Type or Print) <i>Nellie</i>			First Middle Last <i>Attene Burdette</i>			2a. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <i>6 16 1969</i>			2b. HOUR M <i>16</i>										
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Nov 5, 1905</i>		6. AGE (In years last birthday) <i>62</i> YRS		7. UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		8. UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month <i>June</i> Day <i>16</i> Year <i>1969</i>			2d. HOUR M <i>39</i>				
7a. BIRTHPLACE (State or foreign country) <i>Takoma Park, Md.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <i>Montgomery</i>				Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>H. Wife</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>				13b. COUNTY <i>Montgomery</i>				13c. CITY OR TOWN <i>Boyd's</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER <i>Boyd's Md</i>			
14. FATHER'S NAME First <i>Letitia</i> Middle <i>S.</i> Last <i>Poole</i>				15. MOTHER'S MAIDEN NAME First <i>JANE</i> Middle <i>A</i> Last <i>Burdette</i>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16b. SOCIAL SECURITY NO. <i>217-30-0673</i>				17. INFORMANT <i>Husband</i>				ADDRESS <i>SAME</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Hypertensive Cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>15 years</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Obesity</i>																			
19a. DATE OF OPERATION <i>—</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>—</i>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day Year HOUR A.M. <i>19</i> P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>—</i>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>—</i>				21f. LOCATION Street or R.F.D. No. <i>—</i> City or Town <i>Boyd's</i> County <i>Mont.</i> State <i>Md.</i>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>John Fawcett</i>				EXAMINER'S NAME (Type) <i>John Fawcett</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>6/16/69</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>6-18-69</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Boyd's</i>				23d. LOCATION (City or Town) (County) (State) <i>Boyd's Mont. Md.</i>							
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>								ADDRESS <i>Laytonsville, Md.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

483-5X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08523									
CERTIFICATE OF DEATH									
08517									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M
Frank B. W. Burnham						June 6 1969			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
male		white		25 Aug. 1887		81 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		U. S.				Montgomery		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park, Md.		7300 Baltimore Ave..		W. R. Grace Co.		steamship			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Beltsda Wheaton				9710 Bellevue Dr..	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Fred J. Burnham						Zordida Woodward			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No			131-05-2390			Catherine White Burnham			13 a, b, c, d, e
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Broncho pneumonia. Sept 2 day</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pls. Cerebral aneurysm. Marked disability</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 of Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 8/19/1968 to 6/6/1969, that (I) (we) last saw the deceased alive on 6/6/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>Edward T. Morse</i>				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/6/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Edward T. Morse				7300 Carroll Ave Takoma Park Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Cremation		6 June 1969		Cedar Hill Crematory		Suitland, Md.			
24. FUNERAL DIRECTOR				ADDRESS NW., DC		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						JUN 9 1969		<i>Rinaldi Funeral Home</i>	
Rinaldi Funeral Home, Inc. 7400 Georgia Ave									

174X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08524

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08518

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M		
FRANCES		R.		CAKEY	6 2 69		8 AM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE	White		7-15-99		69 YRS				
7a. BIRTH-PLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
PA	USA				MONTGOMERY County Md.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring Md		Holy Cross							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md		Montgomery		Bethesda		YES		64 Ball Street	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
				McLellan		142 S WISH ST WILKES BARRE PA			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Metastases								Several mos	
DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Breast.								Several mos	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, EARN, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (the hospital) attended the deceased from June, 1968, to 6/2, 1969, that (I) (we) last saw the deceased alive on 6/1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G. Lennard Gold				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/2/69			
22d. PHYSICIAN'S NAME (Type) G. Lennard Gold				22e. ADDRESS 9801 Georgia Ave., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE June 4, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Charles Cemetery		23d. LOCATION (City or Town) (County) (State) Sugar Natch, Pennsylvania			
24. FUNERAL DIRECTOR'S NAME (Type) F. Thompson				ADDRESS 8134 Madison Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR JUN 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



4124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Blanche		Middle H.		Last Carroll		2a. DATE OF DEATH Month June Day 3 Year 1969		
3 SEX F			4 RACE W		5 DATE OF BIRTH Aug 24, 1876			6 AGE (in years last birthday) 92 YRS.		2b. HOUR 7:12 A.M.	
7a BIRTHPLACE (State or foreign country) North Carolina			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Kensington			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10231 CARROL PLACE			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.			13b COUNTY -			13c CITY OR TOWN WASHINGTON			13d RESIDE CITY LIM 157 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14 FATHER'S NAME First George W. Middle Scott Last Scott			15 MOTHER'S MAIDEN NAME First Mary Middle Itall Last Itall			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) -			16b SOCIAL SECURITY NO 577-66-7483		
17 INFORMANT Mary C. Erb			Address 3133 Conn. Ave. NW, Wash., D.C.			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 4124 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1961 , to JUNE 3, 1969 , that (I) (we) last saw the deceased alive on JUNE 2, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE Stephen W. DeJeter, M.D.			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED JUNE 3, 1969		
22d. PHYSICIAN'S NAME (Type) STEPHEN W. DEJETER, M.D.			22e. ADDRESS 6719 WILSON LANE, BETHESDA, MD.								
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 6-5-1969			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Count Md		
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.						ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20016			25a. REC'D BY REG. STRAP JUN 9 1969		
						25b. REGISTRAR'S SIGNATURE J. Carlos Judge					



4330

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08526

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08520

1. DECEASED NAME (Type or print) First Middle Last Horace L. Carter			2a. DATE OF DEATH June Month 13 th 1969		2b. HOUR 12:45 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 15, 1879		6. AGE (In years last birthday) 90 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1208 First St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montg.	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1208 First St.	
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 214-12-7338		17. INFORMANT Address Bertie M. Carter Same as item #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> 4550 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Atherosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 hrs. Indefinite					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>H.B.P. + C.H.D.</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/1/65</u> , 19 <u>65</u> , to <u>6/13/69</u> , that (I) (we) last saw the deceased alive on <u>6/13/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stephen N. Jones M.D.</u>			DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>6/13/69</u>	
22d. PHYSICIAN'S NAME (Type) Stephen N. Jones M.D.			22e. ADDRESS 809 Viers Mill Rd., Rockville, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/16/1969	23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION (City or Town) (County) (State) Gaithersburg, Montg. Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Rockville, Md			25a. RECD BY REGISTRAR JUN 16 1969	25b. REGISTRAR'S SIGNATURE <u>William A. Quade</u>	

03.11.11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
08527		CERTIFICATE OF DEATH						08521					
1 DECEASED NAME (Type or print) SANTO			First WMI			Middle CELIA			2a. DATE OF DEATH Month June Day 7 Year 1969			2b. HOUR 9:10 M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH Apr 1, 1899			6 AGE (in years last birthday) 70 YRS		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md				
1d. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wash. Sanitarium			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Barber			12b. KIND OF BUSINESS OR INDUSTRY -					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY 13b		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7730 Eastern Ave NW					
14 FATHER'S NAME Joseph			First WMI			Middle CELIA			15. MOTHER'S MAIDEN NAME First GRACE UNKNOWN			Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 579-12-8959		17 INFORMANT GRACE CELIA			Address 7730 Eastern Ave				
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1967 to June 7, 1969 , that (I) (we) lost the deceased alive on June 7, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Norman H. Rubenstein		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/7/69							
22d. PHYSICIAN'S NAME (Type) NORMAN H. RUBENSTEIN		22e. ADDRESS 1111 N.H. Ave. Silver Spring, Md.											
23a. BURIAL CREMATION, REMOVAL (Specify) ENBURIALMENT		23b. DATE 10 JUNE 1969		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN MAUSOLEUM		23d. LOCATION (City or Town) SUITLAND MD.		(County)		(State)			
24. FUNERAL DIRECTOR PINALI FUNERAL HOME		ADDRESS 7400 GEORGIA AVE. N.W. 20012		25a. REC'D BY REGISTRAR JUN 9 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jordan							

FOR STATE HEALTH DEPT.

08528

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08522

1 DECEASED NAME (Type or Print) <i>DAVID C. CHACE</i>			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>6</i> Day <i>14</i> Year <i>1969</i>			2b HOUR <i>11:05</i> M <i>PM</i>		
3 SEX <i>MALE</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>Nov 20, 1952</i>	6 AGE, in years (last birthday) <i>16</i> YRS	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS HOURS <i></i> MIN <i></i>	2c DATE PRONOUNCED DEAD Month <i>June</i> Day <i>14</i> Year <i>1969</i>		2d HOUR <i>11:05</i> M <i>PM</i>
7a BIRTHPLACE (State or foreign country) <i>Wash DC</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md		
10 CITY OR TOWN OF DEATH <i>Seneca</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>River Rd Rt 112</i>		12a USUAL OCCUPATION (and at work done during most of work ng life, even if retired) <i>Student</i>		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if not institution, residence before admission) STATE <i>MD</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Chesapeake</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First <i>William</i> Middle <i>E.</i> Last <i>CHACE</i>		15 MOTHER'S MAIDEN NAME First <i>Grace</i> Middle <i>Mundough</i> Last <i></i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO. <i>213-56-9454</i>		17. INFORMANT <i>Father - William E. Chace</i> ADDRESS <i></i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple Extreme Injuries</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>incurred in auto accident</i>								
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <i>10:00 AM 6-14-69</i>			21b TIME OF INJURY Month, Day, Year <i>10:00 AM 6-14-69</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>deceased, driver of car, lost control on curve and hit rail</i>		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Street</i>			21f LOCATION Street or R.F.D. No <i>Rto. 190</i> City or Town <i>Seneca</i> County <i>Montgomery</i> State <i>MD</i>		
22a. I certify that I took charge of the remains described above, laid an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Belden R. Reap</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>June 15, 1969</i>		
EXAMINER'S NAME (Type) <i>BELDEN R. REAP</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, City or Town, County, State) <i>14th St. N.W. Washington, D.C.</i>		
23a BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b DATE <i>6/17/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>National Mem. Pk. Cem.</i>		23d LOCATION (City or Town) (County) (State) <i>Falls Church, Va.</i>		
24 FUNERAL DIRECTOR <i>The S.H. Hines Company</i>				25a REC'D BY REGISTRAR <i>JUN 18 1969</i>		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

8160

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13-949-5588

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. PM3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED		Month Day Year		2b HOUR	
ROBERT			HALLOWELL			CHICHESTER		6 25 19 69		7:35 AM	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (n years last birthday)		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HO. RS MIN	
MALE		WHITE		12-18-93		75 YRS					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2c DATE PRONOUNCED DEAD Month Day Year	
MARYLAND			USA					MONTGOMERY		6 25 19 69	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
OLNEY			MONTGOMERY GENERAL			FARMER			FARMING		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)			13b COUNTY			13c CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND			MONTGOMERY			OLNEY				Box 95	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
WASHINGTON B. CHICHESTER			LIZA - HALLOWELL								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO 214-36-4719			17 INFORMANT ADDRESS MEDICAL RECORD DEPT.					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism with Infarction</u> 7 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>due to thrombophlebitis, left leg</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>resulting from burns</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 4/11/ 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) deceased w/ burning trash and parts caught fire					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f LOCATION Street or R.F.D. No City or Town County State Olney Mont. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type) BELDEN R. REAP, M. D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED June 25, 1969		
23a BURIAL CREMATION, REMOVAL (Specify) Burial			23b DATE June 27 1969			23c NAME OF CEMETERY OR CREMATORY St. Johns			23d LOCATION (City or Town) (County) (State) Olney Mont. Md.		
24 FUNERAL DIRECTOR ADDRESS Francis H. Barber Laytonsville Md,						25a REC'D BY REGISTRAR DATE JUN 30 1969		25b REGISTRAR'S SIGNATURE			

Medical Examiner: Dr. John Ball, M.D., Registered
Circumstances of this death are being investigated by me through the coroner's office.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08530

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08524

1. DECEASED NAME (Type or print) First Middle Last Mary Helen Clark		2a. DATE OF DEATH Month Day Year June 1 1969		2b. HOUR M				
3 SEX FEMALE	4 RACE CAUC.	5. DATE OF BIRTH 11-12-97		6. AGE (In years lost birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Martinsburg,		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md		
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) HOLY CROSS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 11495 COLUMBIA PK.	
14. FATHER'S NAME First Middle Last Charles William Clark		15. MOTHER'S MAIDEN NAME First Middle Last Doris B. Carroll		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 578-07-8364-B	17. INFORMANT Address Rev. Roland E. Clark 331 E. Liberty St. Odessa, Ohio
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - Complete Heart Block DUE TO, OR AS A CONSEQUENCE OF (b) Left Bundle Branch Block Undetermined DUE TO, OR AS A CONSEQUENCE OF (c) Arterio-sclerotic Heart Disease Undetermined PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Sept 2, 1964, to June 1, 1969, that (I) (we) last saw the deceased alive on May 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE George L. Ball		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 1, 1969		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 10020 Greenleaf Rd. Silver Spring, Md.						
23a. BURIAL, CREMATION, (REMOVAL) (Specify)		23b. DATE June 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or town) (County) (State) Suitland, Maryland		
24. FUNERAL DIRECTOR Charles E. Johnson, Inc.		ADDRESS 8434 Regis Avenue Baltimore, Md.		25a. REC'D BY REGISTRAR DATE JUN 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
THOMAS			Merrill CLARK			June 9 1969		7:55 AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		
MALE		White		Aug. 11 1914		54 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Texas		U.S.A.				Montgomery Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			9700 Mt. Pisgah Rd			none		none		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Montgomery		Silver Spring		YES		9700 Mt. Pisgah Rd	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Thomas Benjamin Clark			Leta Bell Blackwell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17 INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intestinal virus infection - severe</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> Approximate interval between onset and death: <u>2 hr.</u> <u>36 hr.</u> <u>5 yrs.</u>			
Yes			WW 11		577 07 7527		David M. Clark		723 N. Hampton Dr. Silver Spring, Md.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased from April 9, 1969 to Jun 9, 1969, that (we) lost saw the deceased alive on Jun 7, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (did not) view the body after death.										
22b. SIGNATURE R.D. Bauer M.D.					22c. DATE SIGNED Jun. 9, 1969		22d. PHYSICIAN'S NAME (Type) B.D. Bauer, M.D.			
22e. ADDRESS 2513 Bucklonge Rd. Adelphi, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)				
Burial		6/11/69		Baltimore National		Baltimore Baltimore Md.				
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR JUN 13 1969		25b. REGISTRAR'S SIGNATURE J. J. Jones			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08532

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08526

1 DECEASED-NAME (Type or Print)		First Virginia Middle Victoria Lost Clements		2a DATE KNOWN OF EST. - <input checked="" type="checkbox"/> Month 6 Day 10 Year 69 2b HOUR 2A M	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 10-30-00	6 AGE (in years at birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Holy Cross Hosp		12a USUAL OCCUPATION (Kind of work done during last year if retired) Home maker	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spr.	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 507 Dennis Ave.		12b KIND OF BUSINESS OR INDUSTRY home	
14 FATHER'S NAME First Mathias Middle Matthew Lost Fagan		15 MOTHER'S MAIDEN NAME First Jeanne Middle Harvey Last		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16b SOCIAL SECURITY NO (If yes give war or dates of service) 220-40-5749		17 INFORMANT Charles A. Clements (son)		17b ADDRESS 1719 Dublin Dr. Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Metastatic Carcinoma of Bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month Day Year 4-17 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) Deceased fell over stool at home + 78 ft. slip	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No City or Town County State 507 Dennis Ave Silver Spring Montgomery Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Belden R. Keap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE June 13, 1969		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.		23e. REC'D BY REGISTRAR JUN 16 1969		23f. REGISTRAR'S SIGNATURE Charles Judge	

Fig. 1



08534

08528

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH Month Day Year			2b HOUR M		
Simmie Louis Clinton								June 6, 1969					
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS.	
Male		Negro		May 9, 1920				49 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
Louisiana		U.S.A.				Montgomery Md.							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol give street address)				12a USJA OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY	
Wheaton				12113 Ga. Ave.									
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.				Montg.		Wheaton				12113 Ga. Avenue			
14 FATHER'S NAME				First		Middle		Last		15 MOTHER'S MAIDEN NAME			
Louis Clinton										Suddie Clinton			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes				16b SOCIAL SECURITY NO. (If yes give war or dates of service)				17 INFORMANT Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>										4 hrs			
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary thromboses</u>										6 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
<u>Diabetes</u> <u>Peripheral vascular disease</u> <u>Probable brain lesion</u>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from <u>2/1/68</u> , 19 <u>68</u> , to <u>June 6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/30</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Patrick J. Jamerson</u> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>June 6, 1969</u>					
22d PHYSICIAN'S NAME (Type)						22e ADDRESS <u>11718 Georgia Silver Spring Md.</u>							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
Burial			6/11/69		Sandy Spring Cemetery			Sandy Spring, Montg. Md.					
24 FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>						25a REC'D BY REGISTRAR <u>JUN 13 1969</u> DATE		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4109
Certificate was approved by coroner (Dr. Belden Crap)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08535										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08529																																							
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First <u>Leanne</u> Middle <u>Elizabeth</u> Last <u>Cochran</u>										Month <u>6</u> Day <u>20</u> Year <u>69</u>										12 ²⁵ a.m.																																							
3 SEX <u>Female</u>										4 RACE <u>Caucasian</u>										5 DATE OF BIRTH <u>9-20-12</u>										6 AGE (In years last birthday) <u>56</u> YRS										7 IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN <u></u>										8 IF UNDER 24 HRS HOURS <u></u> MIN <u></u>									
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>										7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A. Amer.</u>										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH <u>Montgomery</u>										Md																			
10 CITY OR TOWN OF DEATH <u>Takoma Park</u>										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanatorium and Hospital</u>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>PBX Operator</u>										12b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>																													
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Maryland</u>										13b. COUNTY <u>Montgomery</u>										13c. CITY OR TOWN <u>Silver Spring</u>										13d. INS. DE CITY - MITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER <u>805 Easley Street</u>																			
14 FATHER'S NAME First <u>Unknown</u> Middle <u></u> Last <u></u>										15 MOTHER'S MAIDEN NAME First <u>Unknown</u> Middle <u></u> Last <u></u>																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown <u>No</u>										16b. SOCIAL SECURITY NO. <u>578-05-1520</u>										17 INFORMANT <u>Curtis Wood-Rt. 355, Staten Ct., Fox Chapel, Pa.</u>										Address <u>Germantown, Md.</u>																													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
										IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>										<u>1 week</u>																																							
										DUE TO OR AS A CONSEQUENCE OF (b) <u>CEREBROVASCULAR ACCIDENT</u>																																																	
										DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u>																																																	
										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																	
										<u>Diabetes, hypertension</u>																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <u>69</u>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>6-18</u> , 19 <u>69</u> to <u>6-20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-19</u> , 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																																																											
22b. SIGNATURE <u>John L. Ford</u>										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED <u>6/20/69</u>																																							
22d. PHYSICIAN'S NAME (Type) <u>JOHN L. FORD</u>										22e. ADDRESS <u>831 UNIVERSITY BLVD. SILVER SPRING MD 20903</u>																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										23b. DATE <u>June 23, 1969</u>										23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>										23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Montgomery, Md.</u>																													
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>										25a. REC'D BY REGISTRAR <u>JUN 25 1969</u>										25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>																																							

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08536										08530														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or Print)					First Middle Last					2a. DATE KNOWN OF DEATH					2b. HOUR									
Denvil					O'Neal					Compton					Month Day Year 1969 6:32M									
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD					2d. HOUR							
Male		White		5 March 1930		39 YRS		MONTHS DAYS		HOURS MIN		Month Day Year 1969 6:32M												
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. COUNTY OF DEATH				Md.								
Georgia				USA				WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				Montgomery												
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY								
Bethesda				The Clinical Center								Position Specialist												
13a. USUAL RESIDENCE (Where deceased lived or admitted to State)				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER								
Washington, D.C.								Wash., DC				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				1101 Third Street, S. W.								
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
Jeptha					Compton					Mary					Brooks									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS									
Yes					1953-1956					257-46-7069					The Medical Record The Clinical Center, NIH, Bethesda, Md. 20014									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) XXXXXX										Exsanguination										4 hours				
DUE TO OR AS A CONSEQUENCE OF										Hemorrhage from laceration of Vena Cava										4 Hours				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										(b)														
DUE TO, OR AS A CONSEQUENCE OF										(c) Surgical operation on Adrenals														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?														
June 17, 1969					Hyperplasia of the Adrenals					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					21b. TIME OF INJURY Month Day, Year					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
2:30 P.M. 6-17, 19 69					Accidental laceration of Vena Cava																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No City or Town County State														
Natl Inst. of Health					Bethesda, Montgomery, Md.																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																								
ACTUAL SIGNATURE					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED														
John G. Ball					M.D.					JUN 18, 1969														
EXAMINER'S NAME (Type)					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					ADDRESS (Street, city, town or county)														
John G. Ball, M. D.					Bethesda, Md.																			
23a. BURIAL (CREMATION REMOVAL (Specify))					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					6-20-69					Westview Cemetery					Atlanta, Georgia									
24. FUNERAL DIRECTOR										25a. REGD BY REGISTRAR										25b. REGISTRAR'S SIGNATURE				
ROBERT A. PUMPHREY, Bethesda, Maryland										JUN 24 1969														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove excess pages, 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

2

1

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08537

08531

1 DECEASED NAME (Type or print)		First	Middle	Lost	2a DATE OF DEATH		2b. HOUR		
Myrtle Marie Cook					Month 6 Day 15 Year 69		M		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		
Female	White		4-26-82		89 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Missouri		Amer.				Montgomery Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Washington San. & Hospt		Housewife					
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Montgomery		Takoma Park				600 Elm Ave	
14 FATHER'S NAME		First	Middle	Lost	15 MOTHER'S MAIDEN NAME		First	Middle	Lost
John Boner					Anna McClellan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17. INFORMANT			Address
No				Unknown		Washington San. & Hospt. Med. Records			Md
18. CAUSE OF DEATH (Enter only one cause per Part 1. Death was caused by IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
411 Acute myocardial infarct								2 d	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic heart disease years									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 5, 1969, to June 15, 1969, that (I) (we) last saw the deceased alive on June 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
ABRAHAM W. DANISH						6-15-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
		1106 Spring St - S.S. Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		June 19, 1969		IOOF Cemetery		Not Co - Craig Missouri			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Arthur Walters		254 Carroll St. N.W.		JUN 19 1969		Charles Judge			

08538

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08532

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH				2b. HOUR				
VIRGIE MARY CORNWELL						ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 30 1969				6 AM				
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD				2d. HOUR		
F	W	Feb. 19 1908	61 YRS.	MONTHS DAYS		HOURS MIN		Month Day Year 1969				7 23 AM		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				Md.	
Virginia			USA						MONTGOMERY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Cabin John			8013 Spring St.											
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. since before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS. DE. CITY LIM. IS?			13e. STREET AND NUMBER		
Md.			MONTGOMERY			Cabin John			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			8013 Spring St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Robert			Annie									Montgomery		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS					
No			None			Walter R. Cornwell, Jr. - same # 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Bronchial Pneumonia.												5 days		
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
Hiatal Hernia and large Esophageal Ulcer -														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED						
John G. Ball								June 30, 1969						
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER										
John G. Ball 7936 Old Georgetown Road				ADDRESS (Street, city, town or county)										
23a. BURIAL, CREMATION, REMOVAL, (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)		
Cremation				7/1/69				Cedar Hill				Prince George, Md.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
Tyson Wheeler Funeral Home Rockville, Md.				JUL 3 1969				Charles Judge						

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>08530</div> <div>08533</div>									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Salvatore Anthony Cortese						<input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> June 13 1969		1:17 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	2 November 1928	40 YRS	MONTHS	DAYS	Month Day Year June 13 1969		1:15 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		USA				Montgomery		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center, NIH			Traffic Assistant		Retail food	
13a. USUAL RESIDENCE (Where deceased lived, if not institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. ASIDE CITY LIMITS?	
New Jersey			West Caldwell			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
						201 Westville Avenue			
14. FATHER'S NAME			15. MOTHER'S M.A.D.E.N. NAME						
First Middle Last			First Middle Last						
Constantino Cortese			Teresa Laico						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			
Yes			1951-1953			The Medical Record, The Clinical Center, NIH, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u>									
410.9 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last									
(b) <u>Arteriosclerotic Heart Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. P.M. 19						
21d. N.A.L.R.Y. OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
<i>Belden R. Read</i>						June 13, 1969			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER						
Belden R. Read, M.D.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial-transit		6/14/1969				Caldwell		N.J.	
24. FUNERAL DIRECTOR					25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE		
1331 Rockville Address Pike					JUN 18 1969		<i>Thomas Judge</i>		
Tyson Wheeler Funeral Home, Rockville, Md.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08540

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08534

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Robert W. Corzine</i>			2a. DATE OF DEATH Month <i>6</i> Day <i>28</i> Year <i>69</i>			2b. HOUR <i>2:00</i> PM	
3 SEX <i>M</i>		4 RACE <i>WHITE</i>		5 DATE OF BIRTH <i>1/31/01</i>		6 AGE (in years last birthday) <i>68</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>N.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md	
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Service Manager</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Automotive</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <i>unknown</i> Middle <i>unknown</i> Last <i>unknown</i>		15. MOTHER'S M maiden name First <i>unknown</i> Middle <i>unknown</i> Last <i>unknown</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown? <i>Yes</i> (If yes give war or dates of service) <i>WW I</i>		16b. SOCIAL SECURITY NO. <i>577-10-8473-8</i>	
17. INFORMANT <i>(Wife)</i>		Address <i>Silver Spring, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Arteriosclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>ASHD = CHF; Bronchitis & Emphysema</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>June 15</i> , 19 <i>69</i> , to <i>June 28</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>June 25</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE <i>Harold W. Draper, M.D.</i>		22c. DATE SIGNED <i>June 29, 1969</i>		22d. PHYSICIAN'S NAME (Type) <i>HAROLD W. DRAPER</i>		22e. ADDRESS <i>9801 GEORGIA AVE, Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial</i>		23b. DATE <i>July 2, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR <i>C. Glen Carter, 8434 Georgia Avenue</i>		25a. REC'D BY REGISTRAR <i>Warner E. Pumphrey, Inc., Silver Spring, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>		DATE <i>JUL 3 1969</i>	

4379

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

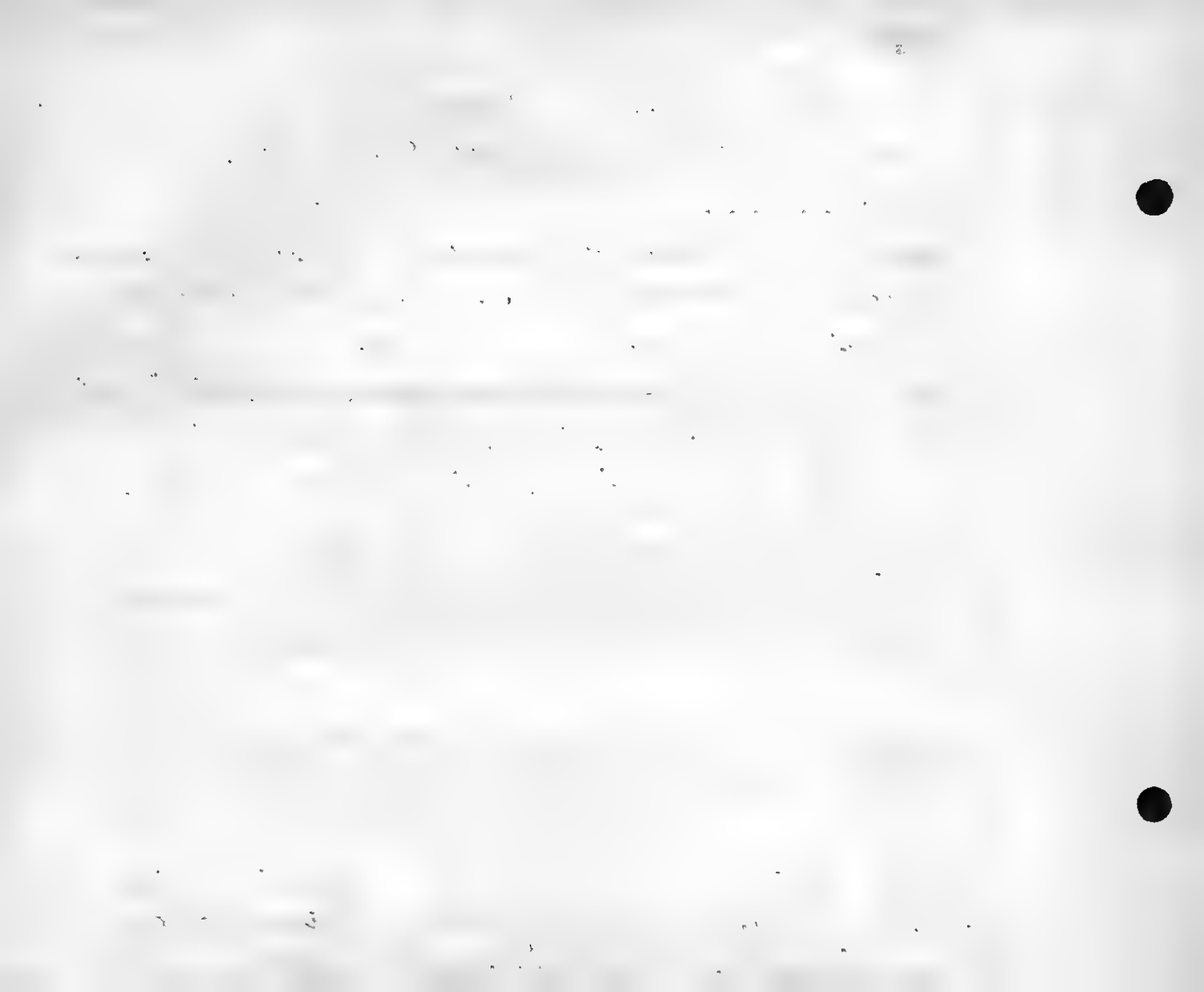
08541

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08535

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Myrtle M. Crompton			2a. DATE OF DEATH Month June Day 19 Year 1969			2b. HOUR 12:30 M					
3. SEX Female		4. RACE white		5. DATE OF BIRTH August 29, 1884		6. AGE (In years last birthday) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Hills Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home					
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2204 Hildarose Drive			
14. FATHER'S NAME First David Middle Duley Last McChessney			15. MOTHER'S MAIDEN NAME First Mary Middle McChessney Last McChessney								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 220-44-1562-7		17. INFORMANT Sil. Spr. Md. June Smalling, 11933 Liers Mill Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 RS 34 RS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute Pyelonephritis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 1967 to June 19, 1969 , that (I) (we) last saw the deceased alive on June 7, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Raymond T. Benack MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/19/69			
22d. PHYSICIAN'S NAME (Type) Raymond T. Benack MD				22e. ADDRESS 4115 Colie Drive, Wheaton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland					
24. FUNERAL DIRECTOR C. Glen Carter 8434 Georgia Avenue Warner E. Humphrey, Inc. Silver Spring, Md.				25a. REC'D BY REGISTRAR DATE JUN 23 1969		25b. REGISTRAR'S SIGNATURE James Judge					



08536

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08542

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

— Clonal Growth Mediated Epitaxially

1 DECEASED NAME (Type or print) Inez		Middle A		Last Crumit		2a. DATE OF DEATH June Month 18 Day 69 Year		2b. HOUR 4:30	
3 SEX female		4 RACE White		5 DATE OF BIRTH March 30, 1887		6 AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) V. Va.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Village 12325 New Hampshire S.S.		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN College Pk.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9301 Limestone Pl.	
14. FATHER'S NAME First First		Middle Middle		Last Last		15. MOTHER'S MAIDEN NAME First First		Middle Middle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO YES		17. INFORMANT Address Nursing Home - 12325 N. Hampshire Ave., Silver Sp. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4104 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-16-1965 to 6-18-1969 , that (I) (we) lost (we) the deceased alive on 9-16-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Morton A. Hirschler MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/18/69	
22d. PHYSICIAN'S NAME (Type) Morton A. Hirschler MD				22e. ADDRESS 9205 New Hampshire Ave					
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE 6-22-69		23c. NAME OF CEMETERY OR CREMATORY Oddfellows cemetery		23d. LOCATION (City or Town) (County) (State) Clarksburg, West Virginia			
24. SIGNATURE OF REGISTRAR Warner E. Pumphrey				25a. REC'D BY REGISTRAR DATE JUN 23 1969		25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey			



FOR STATE HEALTH DEPT.

08543

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08537

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
ROGER		J		CULLINANE				6		3		89		7:10			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
MALE	WHITE	3/2/15		54 YRS		MONTHS		DAYS		6		3		1969		7:10	
7a. BIRTHPLACE (State or foreign country)		7b. C T ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH											
Washington		D. USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery											
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
Silver Spring		Holy Cross Hospital		model maker													
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm. assign)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER											
Maryland		Montgomery		S. SMD.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10417 Huntley Ave. SSMD									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
Roger		J		Cullinane				Elizabeth		T.		Whelan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS											
yes		WWII		579-38-4359		wife Loretta		10417 Huntley Ave. SSMD.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
		Acute Coronary Insufficiency		Coronary Artery Heart Disease													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				Generalized Carcinomatosis, Primary site unknown													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASS STANT MED CAL EXAMINER		22b. DATE SIGNED											
EXAMINER'S NAME (Type)		Belden R. Reap MD		DEPUTY MEDICAL EXAMINER		JUNE 3, 1969											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
Burial		6-6-69		Gate of Heaven		Silver Spring, Md.											
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Francis J. Collins		JUN 9 1969		J. Collins													
500 University Blvd. W. Silver Spring, Md.																	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08544

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08538

1 DECEASED-NAME (Type or print) <i>James B. Davis Jr.</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>12</i> Year <i>1969</i>			2b. HOUR <i>3:20</i> P.M.	
3 SEX <i>male</i>		4. RACE <i>white</i>		5 DATE OF BIRTH <i>5/9/40</i>		6 AGE (In years lost birthday) <i>29</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Sales, Inc.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Sales Rep.</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived on admission) STATE <i>Md.</i>		13b. CITY OR TOWN <i>Prince George's</i>		13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>6912 - Lament Drive</i>	
14. FATHER'S NAME First <i>James B.</i> Middle <i>Davis</i> Last <i>Jr.</i>			15. MOTHER'S MAIDEN NAME First <i>Irene</i> Middle <i>Tyrell</i> Last <i>Tyrell</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <i>no</i>		16b. SOCIAL SECURITY NO. <i>220-34-8873</i>		17 INFORMANT <i>Mr. James B. Davis, Sr.</i>		Address <i>16912 Lament Drive, Prince George's, Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Insufficiency</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Pulmonary Edema & Pleural Effusion</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>metastatic carcinoma to heart</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Coronary left lung Intussusception small intestine with perforation & free peritonitis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/17</i> , 19 <i>69</i> , to <i>4/12</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>6/12</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Francis J. Donovan</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>6/13/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Francis J. Donovan</i>				22e. ADDRESS <i>8218 Winc Ave. Bethesda, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>6-16-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION (City or Town) (County) (State) <i>Beltsville Spring Maryland</i>	
24. FUNERAL DIRECTOR <i>Francis J. Donovan 500 Union Blvd. W. Bel. Sp. Ind.</i>				25a. REC'D BY REGISTRAR <i>JAN 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08545

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08539

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P 4:00 M	
James			Terrence Davis, II			June 22 1969				
3. SEX Male		4 RACE White		5. DATE OF BIRTH 4 October 1968		6 AGE (in years last birthday) YRS. 8 MONTHS 18 DAYS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Child		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. CITY OR TOWN Prince Georges		13c. CITY OR TOWN District Hgts		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7618 Atwood Street		
14 FATHER'S NAME James			First	Middle	Last	15 MOTHER'S MAIDEN NAME Kaye			First Middle Last Arnold	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO. None		17 INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hemorrhagic pneumonitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute hemorrhagic meningoencephalitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute lymphocytic leukemia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 5 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>16 June</u> , 19 <u>69</u> , to <u>22 June</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>22 June</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>Brian Goodell</i>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 22 June 1969		
22d PHYSICIAN'S NAME (Type) Brian Goodell, M.D.						22e ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County), (State)				
Burial		25 June 1969		Potomac Memorial Park		Keyser		W. Va.		
24. FUNERAL DIRECTOR <i>Harry W. Haight</i>						ADDRESS <i>Lysenville, Md.</i>		25a. REC'D BY REGISTRAR DATE JUN 25 1969		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08546

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08540

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Lesta</i> First <i>I</i> Middle <i>Sams</i> Last			2a. DATE OF DEATH Month <i>June</i> Day <i>14</i> Year <i>1969</i>			2b. HOUR <i>2:20</i> M	
3 SEX <i>Female</i>		4. RACE <i>White</i>		5 DATE OF BIRTH <i>3/20/1907</i>		6 AGE (In years lost birthday) <i>76</i> YRS.	
7a BIRTHPLACE (Store or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Musician</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>		13b COUNTY <i>Mont</i>		13c CITY OR TOWN <i>Silver Sp</i>		13d. ASIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <i>Thomas</i> First <i>Reese</i> Middle <i>Cassidy</i> Last		15 MOTHER'S MAIDEN NAME <i>Maria</i> First <i>Cassidy</i> Middle <i>Cassidy</i> Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	
17 INFORMANT <i>Daughter</i>		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Emphysema, Pulmonary</i> <i>492X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1969</i> , 19 <i>69</i> , to <i>June 14</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>June 14</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>J. Peabody Jr.</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>6-14-69</i>			
22d PHYSICIAN'S NAME (Type) <i>Joseph W. Peabody, Jr.</i>		22e ADDRESS <i>1234 19th N.W. Wash DC</i>					
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE <i>6/18/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Floral Hill Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Wheetersburg, Ohio</i>	
24 FUNERAL DIRECTOR <i>Tyson Wheeler</i>		ADDRESS <i>Funeral Home 1331 Rockville</i>		25a REC'D BY REGISTRAR <i>18 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 9-11 are to be filled in by the Maryland State Department of Health
113 6-18-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08547

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08541

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>			Month Day Year			2b. HOUR		
James			Hunter			Decker			June 6, 19 69			4:50		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	10/2/43	25	MONTHS	DAYS	HOURS	MIN	Month June Day 6 Year 19 69			5:20			
7a. BIRTHPLACE (State or foreign country)			7b. CIT. ZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland			U.S.A.						Montgomery			Howard		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. JSUA OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Olney			Montgomery General			Economist			Research					
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Montgomery			Kensington			YES <input type="checkbox"/> NO <input type="checkbox"/>			4903 Flanders Avenue		
14. FATHER'S NAME			15. MOTHER'S M.A.DEN NAME											
Clifford			Floyd			Decker, Jr.			Edna			Moreland		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
no			230-54-4972			records			Montgomery General Hospital, Olney, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY.														
IMMEDIATE CAUSE (a) Multiple extreme injuries including														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) fractured skull due to auto accident														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
				4:52 PM 6/6 19 69				Deceased was passenger in car which flipped over on curb.						
21a. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)				21f. LOCATION Street or RFD No City or Town County State						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				Street				Rte 108 nr Trotter Rd. Howard Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED						
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				June 6, 1969						
Beldon R. Reap, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY						
Burial				June 10, 1969				Columbia Gardens						
24. FUNERAL DIRECTOR				23d. LOCATION (City or Town) (County) (State)				25a. REC'D BY REGISTRAR						
Ives Funeral Home, Inc. Arlington, Va.				Arlington Virginia				25b. REGISTRAR'S SIGNATURE						
				25a. REC'D BY REGISTRAR				DATE JUN 12 1969						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08548 CERTIFICATE OF DEATH 08542									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
William Albert			DILLON			Month Day Year 6 24 69			10:49 PM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER 1 YEAR	
M		CAU		2-18-88		81 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH
VIRGINIA			USA						MONTGOMERY Md
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA			GASVENOR LANE NURSING HOME			PAINTER			BUILDING
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER
MD			PRINCE GEORGES			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3313 40TH PL., COLMAR MANOR
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last ASHTON			First Middle Last DILLON ANNIE STONNE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			
YES <input checked="" type="checkbox"/> WWI			579-10-1668			Etta Shilow Colmar Manor, Md			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u>									1 day
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic decubitus ulcers</u>									3 months
DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral vascular thrombosis</u>									5 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>march</u> , 19 <u>69</u> , to <u>June 24</u> , 19 <u>69</u> , that (I) (we) saw the deceased alive on <u>24 June</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
<u>Walter E. Gasch, MD</u>						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		6/24/69	
22d. PHYSICIAN'S NAME (Type) <u>WALTER E. GASCH MD</u>						22e. ADDRESS <u>2309 SHOREFIELD RD WHEATON MD</u>			
23a. BURIAL, CREMATION, REMOVA. (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			June 28, 1969		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR	
F. Gasch's Sons						Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE	
								JUN 30 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>7</div> <div>1</div> <div>08549</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>08543</div>											
1 DECEASED NAME (Type or print) Thomas			First Middle Last Donnelly			2a. DATE OF DEATH Month 6 Day 24 Year 69			2b. HOUR 4:35 ^P		
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH 2/10/1905			6. AGE (In years lost birthday) 64 YRS		IF UNDER 1 YEAR MONTHS 1 DAYS 15		
7a. BIRTHPLACE (State or foreign country) Australia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery,			Md.		
10 CITY OR TOWN OF DEATH Bethesda,		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Lane Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ins. Man; Bartender			12b. KIND OF BUSINESS OR INDUSTRY -			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN W. Hyattsville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 5441-16th Avenue,		
14 FATHER'S NAME First Middle Last Thomas Donnelly			15 MOTHER'S MAIDEN NAME First Middle Last Elsie Buttle								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes (If yes give year or dates of service) WWII			16b. SOCIAL SECURITY NO. 214 14 0453		17 INFORMANT Helen Donnelly, Address 5441-16th Ave., Apt. 204 W. Hyattsville, Maryland						
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) probable myocardial infarction DUE TO, OR AS A CONSEQUENCE OF arteria (b) 4mo. DUE TO, OR AS A CONSEQUENCE OF cancer of the bladder (c) unknown										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4th.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) curinary retention											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 6-17 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 6-17 1969 6/24 69							
22a. I certify that (I) (this hospital) attended the deceased from 6/24 19 69 , to 6/24 19 69 , that (I) (we) lost saw the deceased alive on 6/24 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE David M. [Signature]				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/24					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/27/1969		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR JUN 30 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



5-3 X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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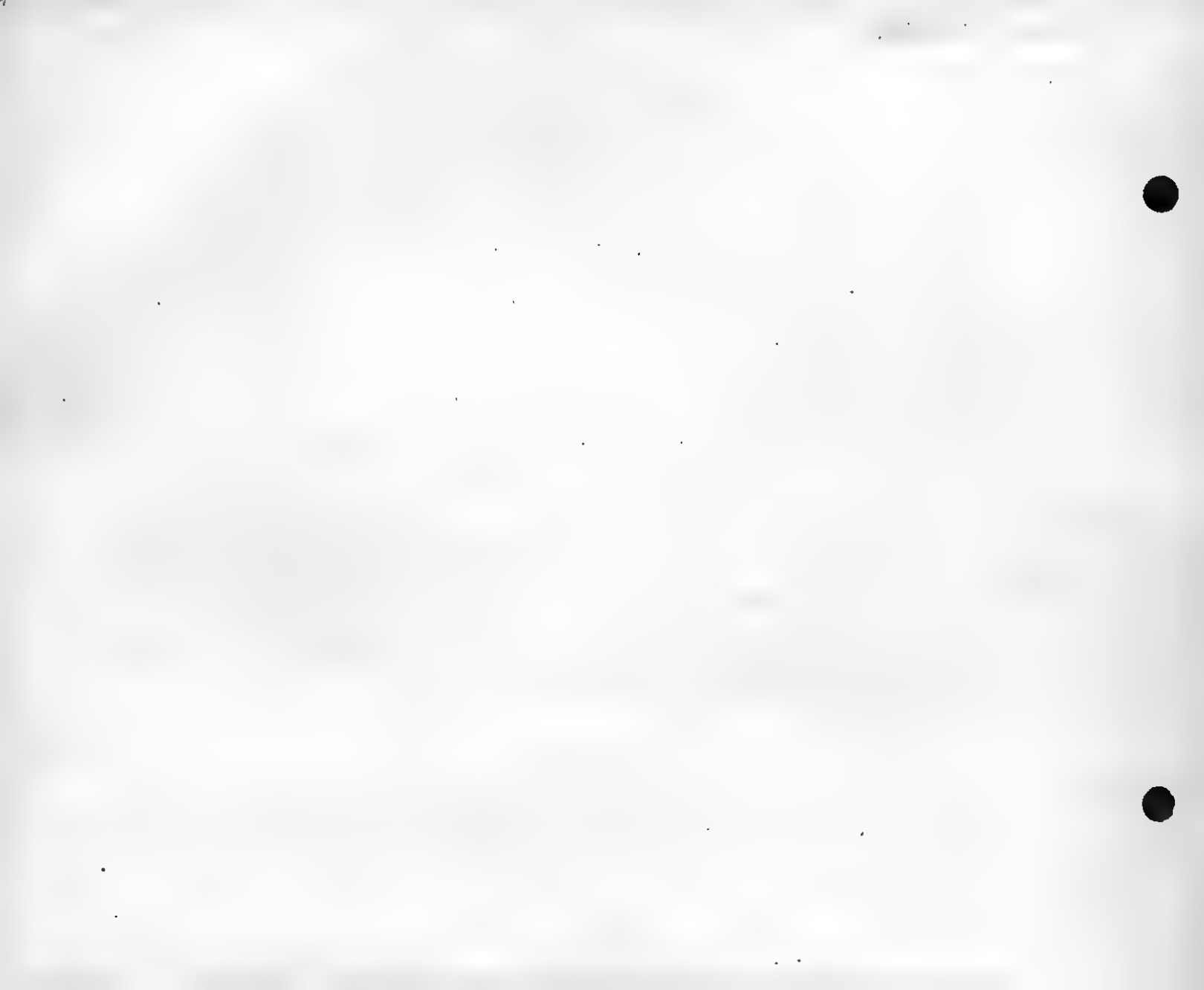
08550

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08544

1 DECEASED-NAME (Type or print) First Middle Last Lee Monroe DUKE			2a DATE OF DEATH Month Day Year June 8 1969		2b HOUR 9:30 M
3 SEX Male		4 RACE Cauc	5 DATE OF BIRTH 8 October 1908		6 AGE (In years last birthday) 60 YRS.
7a BIRTHPLACE (State or foreign country) Missouri		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital, Beth Md		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired USN	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia		13b COUNTY Vienna	13c CITY OR TOWN Vienna	13d INSIDE CITY, TOWN, OR VILLAGE? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 500 Mashie Dr.
14. FATHER'S NAME First Middle Last George Albert Duke			15. MOTHER'S MAIDEN NAME First Middle Last Jessie White		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO 1941-1968		17 INFORMANT Reva D. Duke 500 Mashie Dr. Vienna, Va.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic renal failure secondary to glomerulo-nephritis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that this hospital attended the deceased from <u>6 May</u> , 19 <u>69</u> to <u>8 June</u> , 19 <u>69</u> , that (if we) last saw the deceased alive on <u>8 June</u> , 19 <u>69</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Peter T. Kirchner				22c. DATE SIGNED 9 June 1969	
22d. PHYSICIAN'S NAME (Type) Peter T. Kirchner, M.D.				22e ADDRESS Naval Hospital, Bethesda, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 11 June 69		23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	
23d LOCATION (City or Town) (County) (State) Arlington Virginia					
24. FUNERAL DIRECTOR Money and King Funeral Home Vienna, Va.				25a REC'D BY REGISTRAR DATE JUN 13 1969	
				25b REGISTRAR'S SIGNATURE G. J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Placed by medical examiner

2509

08551

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08545

1. DECEASED-NAME (Type or print) First Middle Last HERBERT LOUIS DUVAL			2a. DATE OF DEATH Month 6 Day 30 Year 69		2b. HOUR 12:27 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 10-16-08		6. AGE (In years last birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETRADER		12b. KIND OF BUSINESS OR INDUSTRY TIRE
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN OLNEY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 21	
14. FATHER'S NAME First Middle Last JEFFREY - BUVAL		15. MOTHER'S MAIDEN NAME First Middle Last FLORENCE - WILLIAMS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 214-18-8639		17. INFORMANT MEDICAL RECORD DEPT.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intermittent cardiac conduction disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yrs 15 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>June</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A.D. Bonifant</u>			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>6/30/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>A.D. BONIFANT</u>		22e. ADDRESS <u>Sandy Springs, Md</u>			
23a. BURIAL, CREMATION, REBURY (Specify)	23b. DATE <u>7-3-69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		23d. LOCATION (City or Town) (County) (State) <u>Laytonsville Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber Laytonsville, Md. 20760</u>			25a. REC'D BY REGISTRAR <u>JUL 3 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



7769

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08552

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08546

Items #1, 12 taken from birth certificate

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) BABY GIRL		Middle EARLEY Earley		2a. DATE OF DEATH Month 6- Day 14- Year 69		2b. HOUR 11:05	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-14-69		6. AGE (In years last birthday) YRS. MONTHS DAYS 5 3 35	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE MD CITY P.		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER 6000 M. Street, S.E.	
14. FATHER'S NAME First Francis Middle A/ Last Earley		15. MOTHER'S MAIDEN NAME First Lillian Middle Rose Last Haynes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Hospital chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity DUE TO, OR AS A CONSEQUENCE OF (b) Massive aspiration DUE TO, OR AS A CONSEQUENCE OF (c) unknown							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Herbert M. Solomon MD				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) Herbert M. Solomon M.D.				22e. ADDRESS 9751 Telegraph Road, Seabrook Md.			
23a. BURIAL CREMATION, ETC. Burial		23b. DATE 6/17/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				25a. REC'D BY REGISTRAR JUN 19 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08553					08547				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
James			Alonso	Early	SR.	Month Day Year June 13 1969			11:40 AM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
male		white		12-13-03		65 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Montgomery Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUS-NESS OR INDUSTRY
Takoma Park			Washington Sanitarium Hospital			Self Employed			PETROLEUM
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			PRINCE GEORGE		Brandywine		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PO Box 6
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
James			A.	Early		Mary			P. Bean
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b SOCIAL SECURITY NO		17. INFORMANT				
No			577-09-0533		Records - Washington Sanitarium Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE									3 WEEKS
DUE TO, OR AS A CONSEQUENCE OF									
(b) CARCINOMA LUNG									6 MONTHS
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
EMPHYSEMA									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
22a. I certify that (I) (this hospital) attended the deceased from MAY 2, 1969, to JUNE 13, 1969 that (I) (we) last saw the deceased alive on JUNE 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE			22c DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			
Robert L. Krichmar MD			JUNE 13 1969			ROBERT L. KRICHMAR MD			
22e ADDRESS			22f. PHYSICIAN'S SIGNATURE						
7733 MASKA AVENUE NW			WASHINGTON DC 20012						
23a B. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		6-16-69		ST PAULS CEMETERY		BADEN, P.G. MD.			
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HUNTT FUNERAL HOME, WADDORE, MD.						JUN 16 1969		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in its entirety by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08554

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08548

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR	
William		Henry	England		June		8	1969	7:15 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		F UNDER YEAR		IF UNDER 24 HRS		
male	white	May 25, 1918		31 YRS		MONTHS		DAYS		HOURS
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
7a. Maryland	7b. U.S.A.			Montgomery						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		Suburban		None		Spot				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Md.		Mont.	Bethesda		YES <input type="checkbox"/> NO <input type="checkbox"/>	9214 - 5th St. SE.				
14. FATHER'S NAME		First	Middle	Last	5. MOTHER'S MAIDEN NAME		First	Middle	Last	
William		H.	England		NORAH				Collins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address				
YES		W.W.H.		Regina F. England						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction, old and recent										Immediate
4109 DUE TO, OR AS A CONSEQUENCE OF										yes
(b) Coronary thrombosis										yes
DUE TO, OR AS A CONSEQUENCE OF										yes
(c) Coronary arteriosclerosis, severe										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION		Street or R.F.D. No		City or Town		County
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										State
22a. I certify that (I) (the hospital) attended the deceased from 6/28, 1968, to 5 June, 1969, that (I) (we) last saw the deceased alive on 8 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
Horace W. Bernton								6/9/69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
Horace W. Bernton										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		6-12-69		Gate of Heaven		Silver Spring		(Md.)		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Robert A. Pumphrey						JUN 16 1969				
7557-Wisconsin Ave., Bethesda, Md.										

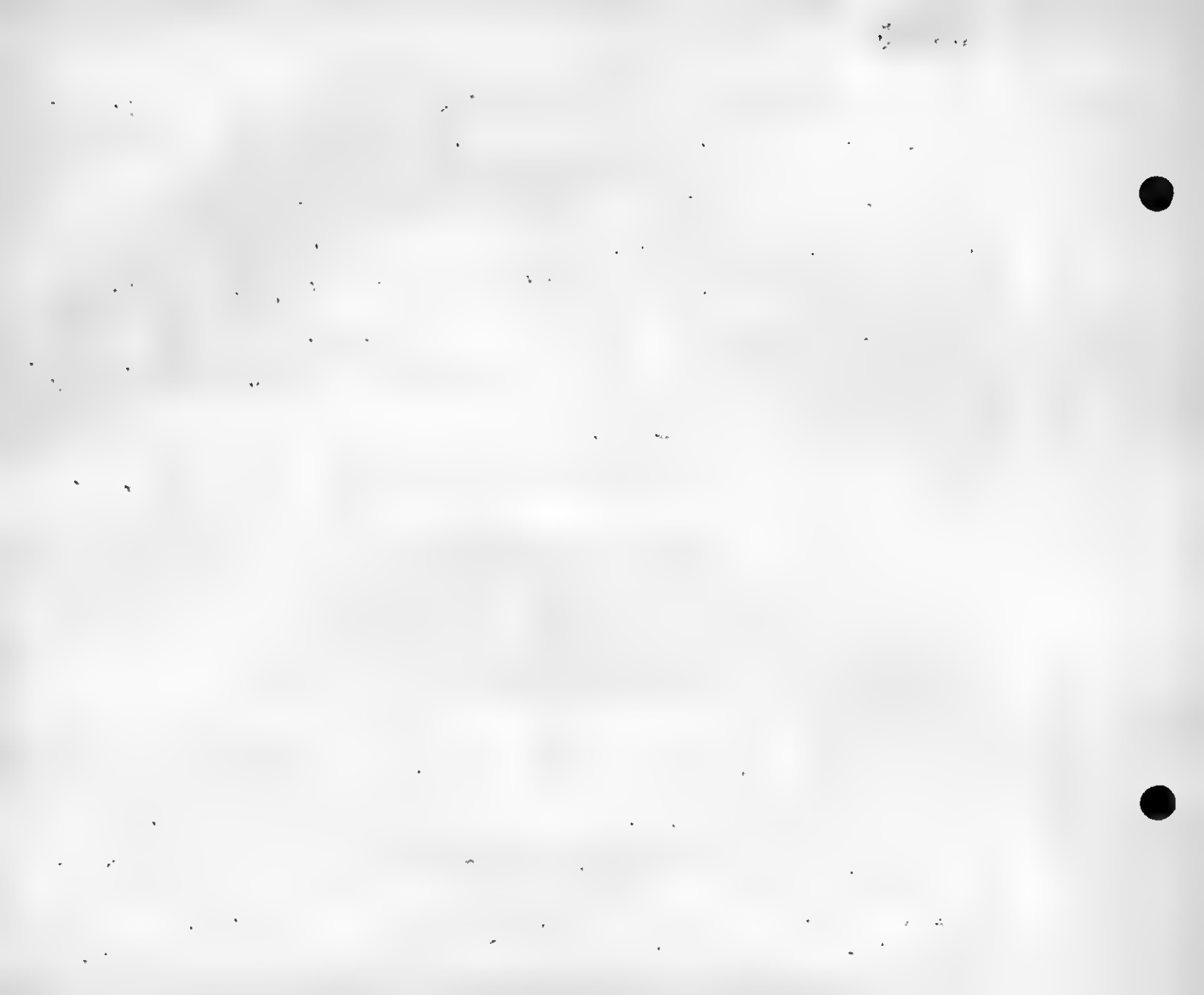


4319

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08555		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08549	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2c. DATE OF DEATH Month Day Year	
JOSEPHINE					ERTTER	JUNE 5 1969	
3. SEX		4. RACE		5. DATE OF BIRTH		2b. HOUR	
FEMALE		WHITE		10/22/1893		2-A M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
D.C.		U.S.				MONTGOMERY	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
SILVER SPRING, MD.			HOLY CROSS HOSPITAL			none	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
MARYLAND			MONTGOMERY		SILVER SPRING		13e. STREET AND NUMBER
							1304 WOODSIDE PARKWAY
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME				
First Middle Last			First Middle Last				
Charles Henry Moore			Nellie James Sullivan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		
					Address Silver Spring, Md. John J. Ertter, 1304 Woodside Parkway		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE							3 1/2 HRS
4317 DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS							YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from MAY 24, 1961, to JUNE 5, 1969, that (1) (we) last saw the deceased alive on JUNE 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED	
James A. Roberts				MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		JUNE 5, 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
JAMES A. ROBERTS M.D.				8907 GEORGIA AVE. SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
		June 7, 1969		St. Philip Cemetery		Washington, D.C.	
24a. FUNERAL DIRECTOR				24b. ADDRESS		25a. REC'D BY REGISTRAR	
Glen Carter				4431 S. Washington, D.C.		JUN 10 1969	
						25b. REGISTRAR'S SIGNATURE	
						Melvin J. [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4369

08556		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08550	
CERTIFICATE OF DEATH					
1. DECEASED NAME (Type or print) <i>Mary L. Etchberger</i>			2a. DATE OF DEATH <i>6</i> Month <i>16</i> Day <i>69</i> Year		2b. HOUR <i>10:35</i> AM
3 SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>9/7/1880</i>		6 AGE (In years last birthday) <i>88</i> YRS.	IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <i>Va.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Baltimore</i>	13c CITY OR TOWN <i>Baltimore</i>	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e STREET AND NUMBER <i>904 S Street</i>
14 FATHER'S NAME First <i>William C.</i> Middle <i>Nash</i> Last		15 MOTHER'S MAIDEN NAME First <i>Blanch</i> Middle <i>Place</i> Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>Yes (no or unknown)</i>		16b SOCIAL SECURITY NO <i>719-16-2464</i>	17 INFORMANT <i>904 "D" St. Sparrow Point, Md. 21219</i> <i>Daughter - Kathryn Tadlock</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>CEREBROVASCULAR ACCIDENT</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ARTERIOSCLEROSIS - GENERAL</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>11 DAYS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 YRS</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>ACUTE GASTROINTESTINAL HEMORRHAGE - 3 WKS AGO</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> not while at work	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>6/7/69</i> , 19 <i>69</i> , to <i>6/16</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>6/16/69</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Ronald W. Barr</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>6/16/69</i>	
22d PHYSICIAN'S NAME (Type) <i>RONALD W. BARR</i>		22e ADDRESS <i>10401 OLD GEORGETOWN RD BETHESDA</i>			
23a BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	23b DATE <i>6/19/69</i>	23c NAME OF CEMETERY OR CREMATORY <i>Evergreen Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Portsmouth, Va.</i>	
24 FUNERAL DIRECTOR <i>John J. Duda, 7922 Wise Ave. Dundalk, Md.</i>		25a REC'D BY REGISTRAR <i>JUN 18 1969</i>		25b REGISTRAR'S SIGNATURE <i>Thomas J.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1510
30M REV 7-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
08557													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR				
George			H. EVANS			6 22 69			6 30 AM				
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
male		white		1-10-15			54 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
DC			U.S.A.						montgomery				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring				Holy Cross									
13a. USUA. RES DENCE (Where deceased lived, if institution- Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
md.				montgomery				Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		1006 Schindler Drive	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
CLARENCE EVANS			EDNA FITZPATRICK										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT Address #					
No				NONE				RITA EVANS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Thrombotic occlusion, right coronary artery													
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Arteriosclerotic Vascular Disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 6-19, 1969, to 6-22, 1969, that (I) (we) lost saw the deceased alive on 6-22, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE Bernard A. Fitzgerald MD						22c. DATE SIGNED 6-22-69							
22d. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD						22e. ADDRESS 217 UNIV BLVD. EAST, Silver Sp. Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			6/25/69			Gate of Heaven			Wheaton, Ind				
24. FUNERAL DIRECTOR W. W. Laitner			24b. ADDRESS 4748 Wisconsin Ave NW			25a. REC'D BY REGISTRAR DATE IN 27 1969			25b. REGISTRAR'S SIGNATURE William J. Laitner				

MEDICAL CERTIFICATION

4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4339

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
085558									
CERTIFICATE OF DEATH									
08552									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR
John			H Jacob			June 30 1969			2:20 PM
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS	
male	WHITE		10-16-1901			67 YRS.			
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
rust			U.S.A.					Montgomery Md	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Bethesda			Suburban			RECREATIONAL ASSOC.		U.S. STATE DEPT.	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c. CITY OR TOWN		13d. STREET AND NUMBER	
DC			18b COUNTY			Wash		3745 Conn Ave N.W.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Eddie — Jacob			Marie — Jacob						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.			17 INFORMANT			
NO						CEDAR FARAH, BROTHER, Address 314 MASS. AVE. BETHESDA, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>T thrombosis of left middle cerebral artery</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic vascular disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced senile Emphysema</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Acute Bronchitis</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>March, 1967</u> to <u>THE PRESENT</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we) (do)</u> (did not) view the body after death.									
22b SIGNATURE			22c. DATE SIGNED						
Edward W. Youngblood			June 30, 1969						
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS						
EDWARD W. YOUNGBLOOD, M.D.			4900 MASSACHUSETTS AVE, N.W.						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
CREMATION			7/1/69		CEDAR HILL CREMATORY		SUITLAND, MD.		
24. FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
JOSEPH GAWLER'S SON, INC.			DATE JUL 7 1969			Richard Judge			
25c WISC. AVE., N. W. WASH., D. C. 20014									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

4339

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First <i>Mary</i>			M'ddle <i>Agnes</i>			Last <i>Farrell</i>		
3 SEX <i>F</i>			4 RACE <i>Can</i>			5 DATE OF BIRTH <i>Dec 16, 1900</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>22</i> Year <i>1969</i>		
7a BIRTHPLACE (State or foreign country) <i>WASH D.C.</i>			7b CITIZEN OF WHAT COUNTRY? <i>AMERICA</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			6. AGE (In years last birthday) <i>68</i> YRS.		
7c CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Holy Cross Hospital</i>			9 COUNTY OF DEATH <i>MONTGOMERY COUNTY, MD</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i>		
10 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD</i>			11b. CITY OR TOWN <i>Rockville</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			13e STREET AND NUMBER <i>14704 Elissa Drive</i>		
14 FATHER'S NAME First <i>JOSEPH</i> M'ddle <i>W.</i> Last <i>MCCANN</i>			15 MOTHER'S MAIDEN NAME First <i>MARY</i> M'ddle <i>A.</i> Last <i>MCDERMITT</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name of unknown) (if yes give war or dates of service) <i>No</i>			17 INFORMANT <i>Mrs. P. Foster</i>		
16b SOCIAL SECURITY NO <i>578 48 2156</i>			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cerebral thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>cerebro-vasc. AS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>			19a DATE OF OPERATION			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		
21c. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21d LOCATION Street or R.F.D. No City or Town County State			21e INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21f HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
22a. I certify that (I) (this hospital) attended the deceased from <i>6-16, 1969</i> , to <i>6-22, 1969</i> , that (I) (was) last saw the deceased alive on <i>6-22, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did not) view the body after death			22b. SIGNATURE <i>D. J. Sengstack M.D.</i>			22c. DATE SIGNED <i>6-23-69</i>			22d. PHYSICIAN'S NAME (Type) <i>George F. Sengstack</i>		
22e ADDRESS <i>9241 Columbia Blvd., Silver Spring, Md.</i>			23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>June 25, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		
23d LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>			24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons</i>			25a REC'D BY REGISTRAR <i>JUN 26 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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1621
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08560 CERTIFICATE OF DEATH 08554									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
David (None) Feldman						Month Day Year June 5 1969			2:47 AM
3. SEX	4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		7 UNDER 1 YEAR	
Male	White		January 15, 1887			82 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Poland	American				Montgomery Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington Sp + Hosp.			Restaurant worker			WAITER
13a USUAL RESIDENCE (Where deceased lived, if institution Res. den. before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			MONT.		Silver Spring		YES		310 Springloch Rd.
14. FATHER'S NAME			15. MOTHER'S MARRIAGE NAME			Address			
First Middle Last Louis Feldman			First Middle Last Celia						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17. INFORMANT			
None			088-10-9995			Pr's. Chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Failure, Anemia</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRONCHOGENIC CARCINOMA WITH METASTASES</u> 6 MONTHS DUE TO, OR AS A CONSEQUENCE OF (c) <u>1621</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home farm, street factory) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 1965</u> to <u>JUNE 5, 1969</u> , that (I) (we) last saw the deceased alive on <u>JUNE 4, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE			DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED		
Robert L. Krachmar							JUNE 5 1969		
22d PHYSICIAN'S NAME (Type)			22e ADDRESS						
ROBERT L. KRACHMAR MD			7733 ALASKA AVENUE NW WASHINGTON DC 20012						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		6-6-69		KNOLLWOOD PARK		CAPRESS HILLS N.Y.			
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
Frederick Funeral Home			JUN 9 1969			Robert L. Krachmar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. They please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08561											
CERTIFICATE OF DEATH											
08555											
1. DECEASED-NAME (Type or print) First Middle Last Walter NMI Flore						2a. DATE OF DEATH Month Day Year June 7 1969			2b. HOUR 2:40 AM		
3. SEX male		4. RACE white		5. DATE OF BIRTH 2-3-87		6. AGE (In years last birthday) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY CLERK					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE D.C.		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 5127 3rd ST. N.W.					
14. FATHER'S NAME First Middle Last UNKNOWN				15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 578-48-2197		17. INFORMANT Address RICHARD HUHN, 613-15TH ST. N.W. WASH, D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral and Cardiac Anoxia											
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure											
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Adenocarcinoma of Prostate Metastatic to Bone, Other Organs											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from MARCH, 1969, to THE PRESENT, that (I) (we) last saw the deceased alive on 6/6 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE Edward W. Youngblood MD		22c. DATE SIGNED 6/7/69		22d. PHYSICIAN'S NAME (Type) EDWARD W. YOUNGBLOOD, MD		22e. ADDRESS 4900 MASS. AVE. N.W., WASHINGTON, D.C.					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/12/69		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.					
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS		24a. ADDRESS 5130 WISCONSIN AVE. WASHINGTON, D.C.		25a. REC'D BY REGISTRAR JUN 12 1969		25b. REGISTRAR'S SIGNATURE James Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08562

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08556

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)			First Dolores	Middle Nellie	Last FLOREA	2a. DATE OF DEATH Month JUNE Day 14 Year 1969			2b. HOUR 345P M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 26 June 1897		6. AGE (In years last birthday) 71 YRS		IF UNDER YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY OWN Home				
13a. US-JAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Herndon		13d. INSIDE CITY, IN 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER P.O. BOX 366		
14. FATHER'S NAME First James			Middle STEEP			15. MOTHER'S MAIDEN NAME First Martha			Middle J. RITZ Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown None		16b. SOCIAL SECURITY NO. 578-32-7708		17. INFORMANT Dorothy D. Johnson		Address Minot, North Dakota				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Breast</u> 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>15 May</u> , 19 <u>69</u> , to <u>14 June</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>14 June</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE David W. BAILEY				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 14 June 1969				
22d. PHYSICIAN'S NAME (Type) David W. BAILEY				22e. ADDRESS Naval Hospital, Bethesda, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 14 June 1969		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Com		23d. LOCATION (City or Town) Arlington, Virginia		(County) (State)		
24. FUNERAL DIRECTOR Berkley Green, Herndon, Va.		ADDRESS		25a. REC'D BY REGISTRAR JUN 23 1969		25b. REGISTRAR'S SIGNATURE Charles J. J...				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08563

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08557

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR 45	
3 SEX F		4 RACE W		5 DATE OF BIRTH 4-24-1880		6 AGE (in years last birthday) 89 YRS.		7c UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) Louisiana		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery		10c UNDER 24 HRS HOURS MIN
10 CITY OR TOWN OF DEATH Bensington Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bensington Chubens Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teacher		12b KIND OF BUSINESS OR INDUSTRY		
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Chevy Chase		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4422 Stanford St.
14 FATHER'S NAME Alexander		First	Middle	Last	15 MOTHER'S M.A.D.E.N. NAME HENRIETTA		First	Middle
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b SOCIAL SECURITY NO. 348-160-538A		17 INFORMANT ALLAN FLOTT		Address 4422 Stanford St.		ch. ch. md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 447 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 yrs.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>June</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June 3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b SIGNATURE Marvin Wadler, M.D.				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED June 3, 1969
22d PHYSICIAN'S NAME (Type) MARVIN WADLER				22e ADDRESS 8218 Wisconsin Ave. Bethesda, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 6-6-69		23c NAME OF CEMETERY OR St. Joseph's		23d LOCATION (City or Town) (County) (State) River Grove Cook Ill.		
24 FUNERAL DIRECTOR William H. RYGER				ADDRESS 4523 Middlebrook Rd. Bethesda, Md.		25a REC'D BY REGISTRAR DATE JUN 9 1969		25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please make carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08564

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08558

1. DECEASED NAME (Type or print) First Marion Middle L. Last Flynn			2a. DATE OF DEATH Month June Day 15 Year 1969			2b. HOUR 235 A								
3 SEX Female		4 RACE White		5. DATE OF BIRTH Aug. 12, 1875		6. AGE (In years last birthday) 93 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 24 HRS HOURS 0 MIN 0				
7a. BIRTHPLACE (State or foreign country) D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH MONTGOMERY					
10 CITY OR TOWN OF DEATH Kensington			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens Sanit			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) AT HOME			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN Chevy Chase			13d. INS. DE. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 6908 Maple Ave.		
14. FATHER'S NAME First Clinton Dewitt Middle Lamb. Last			15. MOTHER'S MAIDEN NAME First Marietta Middle Degges. Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. -			17 INFORMANT MRS. THOMAS E. SMITH, GRANDDAUGHTER, DAYTON, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4409 DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) gastroenteritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or RFD No City or Town County State								
22a. I certify that (I) (the hospital) attended the deceased from Feb , 19 68 , to June , 19 69 , that (we) last saw the deceased alive on 6/15 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Marvin Wadler			22c. DATE SIGNED June 15/69			22d. PHYSICIAN'S NAME (Type) MARVIN WADLER			22e. ADDRESS 8218 Wisc. Ave. Beth., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6-17-1969			23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D.C.					
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC. 5130 WISC. AVE., N. W. WASH., D. C. 20016						25a. REC'D BY REGISTRAR JUN 20 1969			25b. REGISTRAR'S SIGNATURE James Judge					

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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085565										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08559																													
1 DECEASED-NAME (Type or print)										2a DATE OF DEATH										2b HOUR																													
John Henry Fort										June 8 1969										M																													
3 SEX Male										4 RACE White										5 DATE OF BIRTH 12-3-09										6 AGE (In years (last birthday)) 59 YRS										7 UNDER 24 HRS MONTHS DAYS HOURS MIN									
7a BIRTHPLACE (State or foreign country) North Carolina U.S.A.										7b CITIZEN OF WHAT COUNTRY?										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery Md																			
10 CITY OR TOWN OF DEATH Takoma Park.										11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Washington Sanitarium & Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret Inspector										12b. KIND OF BUSINESS OR INDUSTRY Government																			
13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Maryland										13b COUNTY P.G.										13c CITY OR TOWN Handover										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 7700 Ridge Drive									
14 FATHER'S NAME First Middle Last William Henry Fort										15 MOTHER'S MAIDEN NAME First Middle Last Hattie E. Taylor										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) Yes										16b SOCIAL SECURITY NO 579 18 6915										17 INFORMANT Washington Sanitarium & Hospital - records									
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))										PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
IMMEDIATE CAUSE (a) Pneumonia										DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) Bronchopneumonia																																							
										(c)																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f LOCATION Street or R.F.D. No City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 3/19/69, 1969, to 6/8/69, 1969, that (I) (we) last saw the deceased alive on 6/8/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																																																	
22b SIGNATURE Lewis Bullock										22c PHYSICIAN'S NAME (Type) Lewis Bullock										22d DATE SIGNED 6/8/69																													
23a. BURIAL, CREMATION REMOVAL (Specify) Burial										23b DATE 6/10/69										23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln										23d LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.																			
24 FUNERAL DIRECTOR Francis Gasch's Sons										25a. REC'D BY REGISTRAR JUN 13 1969										25b. REGISTRAR'S SIGNATURE																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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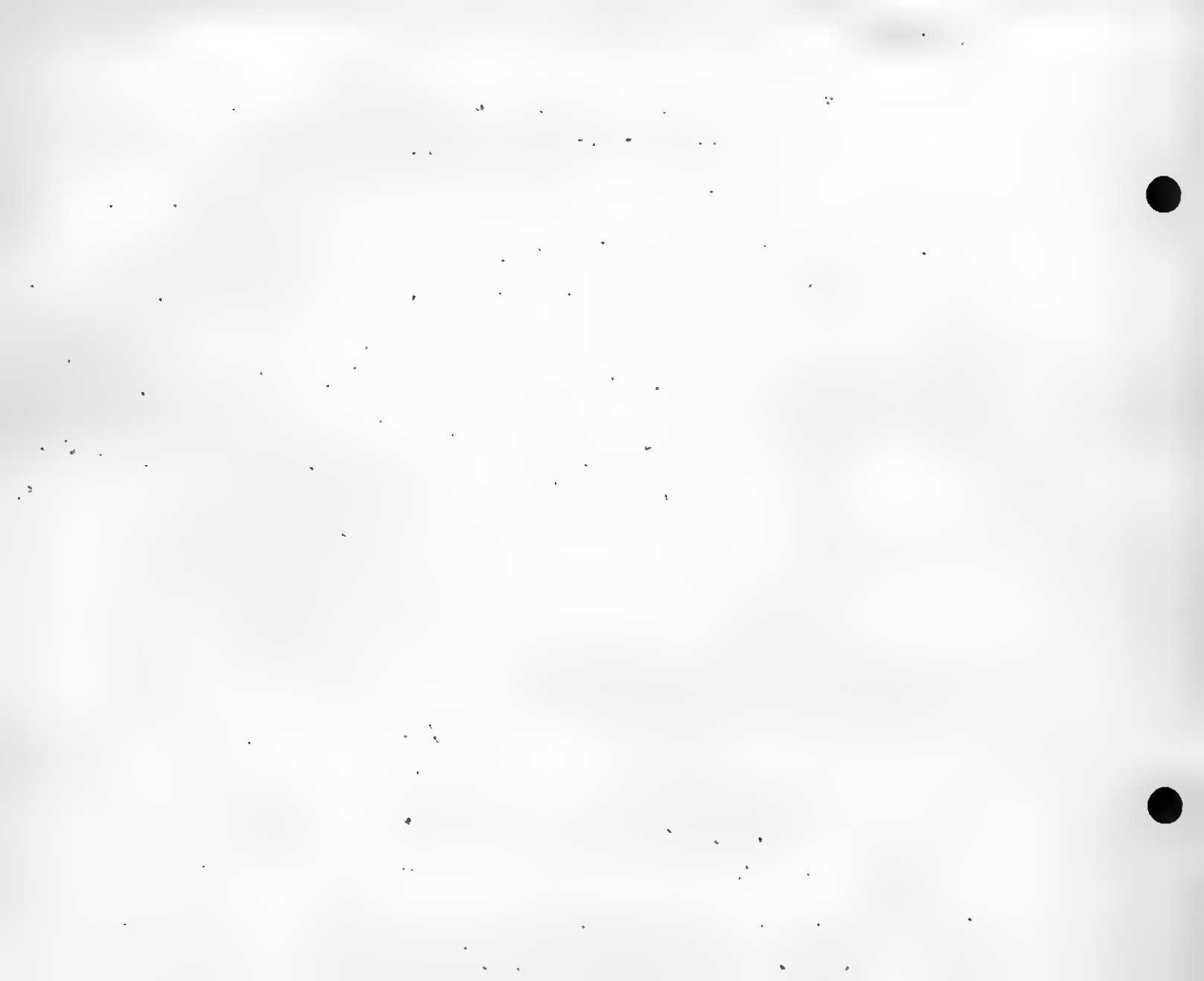
08566

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08560

1 DECEASED-NAME (Type or print) CARRIE M FRANCIS			2a DATE OF DEATH Month 6 Day 4 Year 69		2b HOUR 4:48 PM
3. SEX Female	4 RACE WHITE	5 DATE OF BIRTH 9-30-24		6 AGE (In years last birthday) 44 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) DC	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md.		
10 CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HW Housewife		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY MONT	13c CITY OR TOWN WHEATON	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 11604 ELKIN ST	
14. FATHER'S NAME First ? Middle Lunsford Last Lunsford	15 MOTHER'S MAIDEN NAME First UNKNOWN Middle Last 		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) N/A (If yes give war or dates of service)		
16b SOCIAL SECURITY NO. 577-48-1183B		17 INFORMANT Mr. Vernon J. Francis		Address 7801 Peaceful St Clinton, Md. 20735	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any; which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 5/29/69 to 6/4/69 , that (I) (we) lost saw the deceased alive on 6/4/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE John J. Curry		DEGREE 	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) JOHN J. CURRY, M.D.		22e. ADDRESS 9801 Georgia Ave., Silver Spring Md			
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE June 9, 1969	23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d LOCAT ON (City or Town) (County) (State) Bladensburg, Md.	
24. FUNERAL DIRECTOR W. W. Chambers Co.		ADDRESS 86556 Ave Silver Spring Md.		25a REC'D BY REGISTRAR JUN 9 1969	25b REGISTRAR'S SIGNATURE W. W. Chambers



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> 08567 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08561 </div>											
1. DECEASED NAME (Type or print) <u>Julius</u>				First Middle Last <u>— FROELICH</u>				2a. DATE OF DEATH <u>6 Month 1 Day 69 Year</u>		2b. HOUR <u>5³⁰ P M</u>	
3 SEX <u>MALE</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>3/5/1879</u>		6 AGE (In years last birthday) <u>90</u> YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <u>GERMANY</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONT GOMERY</u> Md					
10 CITY OR TOWN OF DEATH <u>BETHESDA</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>GROESBECK Nursing Home</u>				12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) <u>Merchandise</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Farm Supplies</u>			
13a USJA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>		13b COUNTY <u>MONTGOMERY</u>		13c CITY OR TOWN <u>Clay Chase</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>5531 WARWICK Place</u>			
14 FATHER'S NAME First Middle Last <u>EMANUEL FROELICH</u>				15. MOTHER'S MAIDEN NAME First Middle Last <u>IDA - HEICBORN</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>108-16-9620</u>		17 INFORMANT <u>WALTER FROELICH Son</u> Address <u>5531 Warwick Pl. Chevy Chase MD</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>										<u>1 hr</u>	
4123 (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>										<u>3 yr</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>										<u>5 yr</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Control Thrombosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 21, 1968</u> , to <u>June 1, 1969</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>June 1, 1969</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.											
22b. SIGNATURE <u>Lewis H. Biben MD</u>				DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>6-1-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Lewis H. Biben</u>				22e. ADDRESS <u>916 19TH ST NW Washington DC</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6-3-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETH HAMEDRESH HAGODAH</u>		23d. LOCATION (City or Town) <u>SYRACUSE</u>		(County) <u>IV. Y.</u>		(State)	
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS</u>				ADDRESS <u>WASH. D.C.</u>				25a. REC'D BY REGISTRAR <u>JUN 5 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

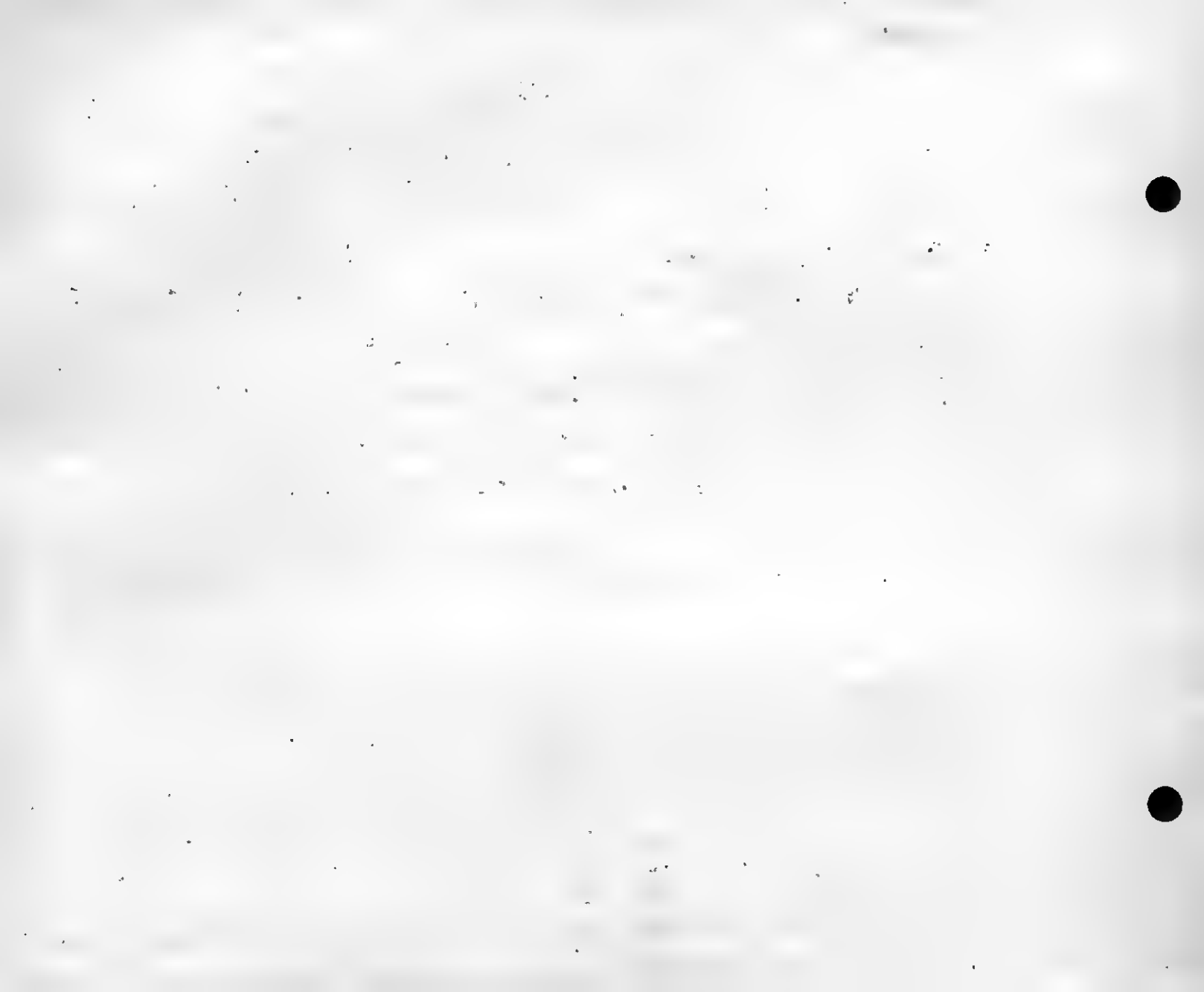
08568

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08562

1. DECEASED NAME (Type or print) First Anna Middle Frosh Last		2a. DATE OF DEATH Month 6 Day 25 Year 69		2b. HOUR 38 M	
3. SEX F		4. RACE W		5. DATE OF BIRTH 20 May, 1908	
6. AGE (In years last birthday) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH HSG Montgomery MD		10. CITY OR TOWN OF DEATH Montgomery County		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Hebrew Home	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) H.W.		12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13b. STREET AND NUMBER 8512 Howard Ave.		13c. CITY OR TOWN Telford		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First JOSEPH Middle MABICK Last		15. MOTHER'S MAIDEN NAME First UNKNOWN Middle Last		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO	
16b. SOCIAL SECURITY NO 523 30 178		17. INFORMANT SON		Address BETH. MD STANLEY B. FROSH - 6100 - BRADLEY BLVD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4379 Anteriosclerosis, cerebral DUE TO, OR AS A CONSEQUENCE OF (b) Anteriosclerosis, generalized DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 15 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Degenerative joint disease, multiple					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from March 10, 1957, to June 25, 1969, that (I) (we) last saw the deceased alive on June 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Heinz J. Lorge, M.D. 6121 Montrose Rd, Rockville, Md. DATE SIGNED June 25, 1969	
22c. PHYSICIAN'S NAME (Type) Heinz J. Lorge		22d. ADDRESS Hebrew Home of Greater Washington		22e. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 6-25-69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREM.	
23d. LOCATION (City or Town) WASH. D.C.		23e. LOCATION (City or Town) (County) (State) DC		23f. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS		ADDRESS WASH. D.C.		25a. REC'D BY REGISTRAR JUN 27 1969	
25b. REGISTRAR'S SIGNATURE		DATE		25c. REGISTRAR'S SIGNATURE	

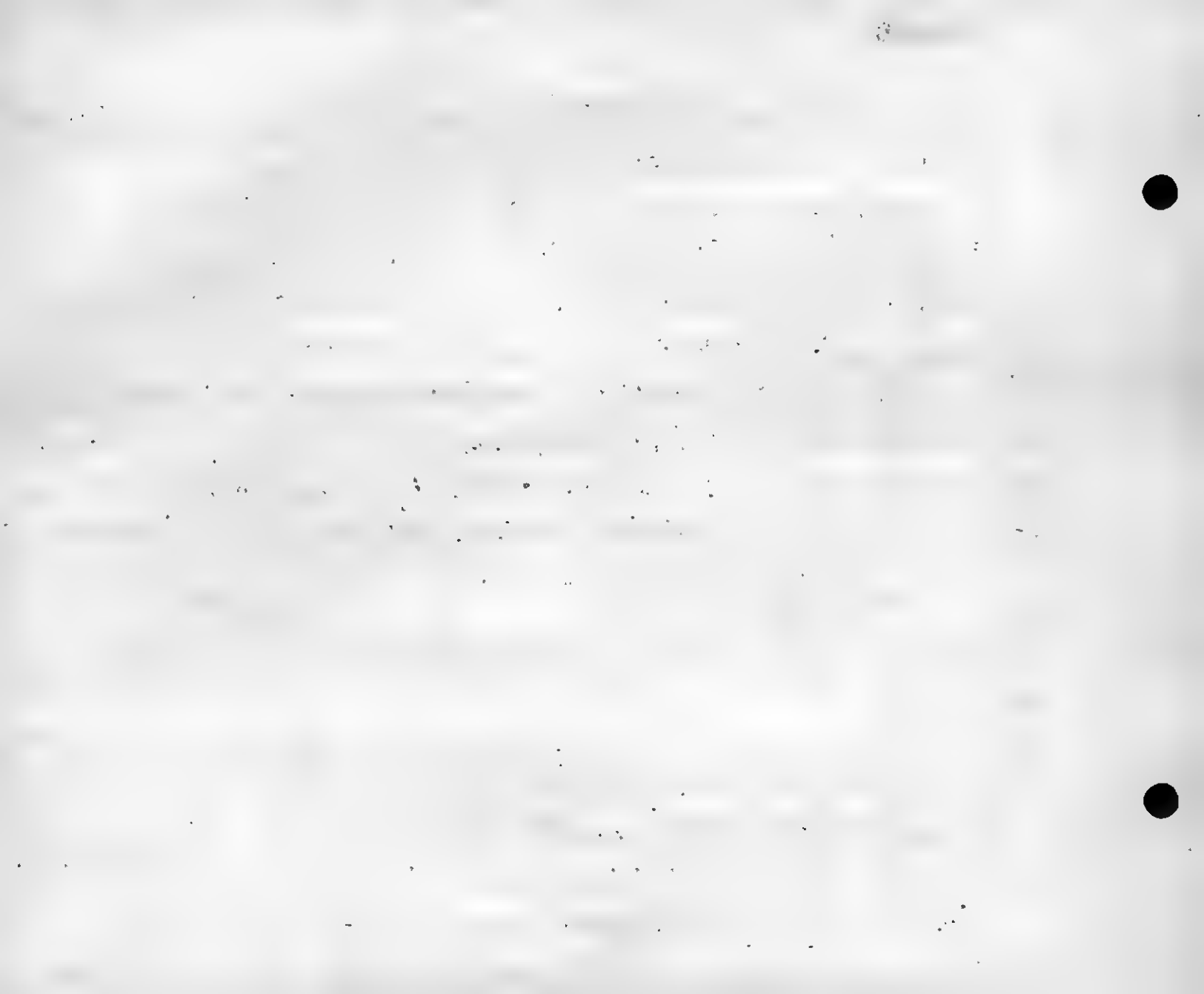


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cloud with Medical Examiner

08569		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08563	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
KAGA NMI Garris						6	23 1969
3. SEX	4 RACE		5 DATE OF BIRTH			6 AGE (in years lost birthday)	
Male	White		6/8/06			63 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Grassey Creek NC, USA						Montgomery Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.)		12b KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital		TV repair			
13a USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Montgomery		SS		500 Finsbury Rd. SSMC	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last				
? Unknown			Unknown?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Address			
none		218-18-9088		son Dan R. Garris 500 Finsbury Rd. SSMC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>lobectomy & pleural effusion & hemorrhagic effusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic bronchogenic carcinoma</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several months</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>metastatic carcinoma brain</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 7, 1967</u> to <u>June 23, 1969</u> , that (I) (we) lost saw the deceased alive on <u>June 16, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Bowditch Hunter, Jr., M.D.</u>		22c DATE SIGNED <u>June 24, 1969</u>		22d PHYSICIAN'S NAME (Type)		22e ADDRESS	
				Bowditch Hunter, M.D.		50 W. Edmonston Street, Rockville, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
<u>burial</u>		6-27-1969		New River Church Cem.		Grassey Creek D.C	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
W. W. Chambers		1400 Chapin St. N.W. Wash. D.C		DATE JUN 30 1969		William Judge	



CERTIFICATE OF DEATH

1308570

1 DECEASED NAME (Type or print) <i>Baby Boy Genesee</i>			2a DATE OF DEATH Month <i>6</i> Day <i>3</i> Year <i>69</i>			2b HOUR <i>10:55 A.M.</i>				
3 SEX <i>Male</i>		4 RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>6/3/49</i>		6 AGE (In years last birthday) <i>19</i>		7 UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery Co.</i>				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp.</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution) STATE <i>md.</i>			13b COUNTY <i>Montgomery</i>			13c INS DE CITY (M IS?) <i>YES</i>			13e STREET AND NUMBER <i>709 Robert Rd.</i>	
14 FATHER'S NAME First <i>Yvon</i> Middle <i>Leavel</i> Last <i>Genesee</i>			15 MOTHER'S MAIDEN NAME First <i>Anne</i> Middle <i>Marie</i> Last <i>Genesee</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				
16b SOCIAL SECURITY NO			17 INFORMANT <i>mother</i>			Address <i>709 Robert Rd. Rockville, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>immaturity</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>James P. Johnson</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE <i>June-7/69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Suburban Hospital</i>			23d. LOCATION (City or Town) (County) (State) <i>Bethesda - Montg. - Md.</i>	
24. FUNERAL DIRECTOR <i>Mrs. Amelia C. Catey Administrator</i>						25a. REC'D BY REGISTRAR DATE <i>JUN 11 1969</i>		25b. REGISTRAR'S SIGNATURE <i>James P. Johnson</i>		

777X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

08571

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08565

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
Robert J. GERHARDT JR.						DATE KNOWN OF DEATH			6-14 1969			11 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	W	JAN 5, 1952	17 YRS	MONTHS DAYS		HOURS MIN.		JUNE 14			11 PM			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			Md			
Ill.		USA		WIDOWED		DIVORCED		Montgomery						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Seneca			River Road Rt 112			Student			High School					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md			Montgomery			Cen Chase			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4214 Oakridge LA.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Robert J. GERHARDT SR.			MARCELLA GUNSON											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
NO			220-44-0608			Edna Harriet HARPER			4214 Oakridge LA.					
18. CAUSE OF DEATH (Enter only one cause per line 19 (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Extreme Injuries														
DUE TO, OR AS A CONSEQUENCE OF (b) incurred in auto accident.														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?				
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH					21b. TIME OF INJURY Month, Day Year					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
<input checked="" type="checkbox"/>					10-18-69 6-14 1969					deceased, passenger, in car in which driver lost control on curve				
21d. INJURY OCCURRED					21e. PLACE OF INJURY (At home, farm, street, factory, other building, etc.)					21f. LOCATION Street or R.F.D. No City or Town County State				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					Street					Rt 190 Seneca Montg. Md				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE					CHIEF MEDICAL EXAMINER					22b. DATE SIGNED				
Belden R. Reap										June 15, 1969				
EXAMINER'S NAME (Type)					DEPUTY MEDICAL EXAMINER					ADDRESS (Street, P.O. box, or county)				
BELDEN R. REAP														
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			6-18-69			Oakridge Cemetery			Oak Park, Illinois					
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
ROBERT A. HUMPHREY, Bethesda, Maryland					JUN 18 1969					J. H. Jones, Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08572

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08566

1. DECEASED NAME (Type or print) <u>Elena Gershan</u>			2a. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>69</u>			2b. HOUR <u>11</u> P M	
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>8-23-67</u>		6. AGE (In years last birthday) <u>1</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Holy Cross Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Minor</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USLA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Wash D.C.</u>		13b. COUNTY <u>DC</u>		13c. CITY OR TOWN <u>Wash D.C.</u>		13d. INSIDE CITY (in 157) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>3305 Macomb St N.W.</u>		14. FATHER'S NAME First <u>Bernard</u> Middle <u>Gershan</u> Last <u>Naomi</u>		15. MOTHER'S MAIDEN NAME First <u>Naomi</u> Middle <u></u> Last <u></u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <u>No</u>		16b. SOCIAL SECURITY NO <u>No</u>		17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Brain Damage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anoxia, Neonatal</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>22 months</u> <u>22 months</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Mental Retardation and Failure to Thrive</u>							
19a. DATE OF OPERATION <u>No</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13, 1967</u> , to <u>6/10, 1969</u> , that (I) (we) last saw the deceased alive on <u>6/10, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Stanley I. Wolf</u> MD				22c. DATE SIGNED <u>6/11/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Stanley I. Wolf MD</u>				22e. ADDRESS <u>8708 1st Ave., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6-12-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>UNITED HEBREW CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY SONS</u>				25a. REC'D BY REGISTRAR <u>JUN 16 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Attest: Judge</u>	

MEDICAL CERTIFICATE ON

4339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08573

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08567

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Alinda P. Ghosh</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>3</i> Year <i>1969</i>		2b. HOUR <i>5:45</i> M
3 SEX <i>male</i>	4 RACE <i>Hindu</i>	5. DATE OF BIRTH <i>10-24-63</i>		6 AGE (In years last birthday) <i>85</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) <i>INDIA</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i> Md.		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>INDUSTRIAL ADVISOR</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>	13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Bethesda</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>5900 JOHNSON AVE.</i>	
14. FATHER'S NAME First Middle Last <i>LAL BEHARI GHOSH</i>	15 MOTHER'S MAIDEN NAME First Middle Last <i>UNKNOWN</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>	16b SOCIAL SECURITY NO <i>219-54-8632</i>	17 INFORMANT <i>STANLEY S. GHOSH-5900 JOHNSON AVE., MD.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE CVA WITH LEFT HEMIPLEGIA</i> <i>4229</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CEREBRAL THROMBOSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CEREBRAL ARTERIO-SCLEROSIS</i> Approximate interval between onset and death <i>7 DAYS</i> <i>7 DAYS</i> <i>20 - 30</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>UREMIA; OLD RIGHT HEMIPARESIS</i>					
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from <i>MAY 27, 1961</i> , to <i>JUNE 3, 1961</i> , that (I) (we) last saw the deceased alive on <i>JUNE 2, 1961</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Joseph P. Connor, M.D.</i>	DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>June 3, 1969</i>		
22d PHYSICIAN'S NAME (Type) <i>JOSEPH P. CONNOR</i>	22e ADDRESS <i>7440 OLD GEORGETOWN RD.</i>				
23a BURIAL OR CREMATION <input checked="" type="checkbox"/> BURIAL <input type="checkbox"/> CREMATION	23b DATE <i>6/4/69</i>	23c NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>	23d LOCATION (City or Town) (County) (Md.) <i>Silver Spring, Montgomery</i>		
24 FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>	ADDRESS <i>Bethesda, Md.</i>		25a. RECD BY REGISTRAR <i>William J. Jones</i>	25b. REGISTRAR'S SIGNATURE	

4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If possible, remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

CLEANED COPY MEDICAL EXAMINER REAP DR. B.

08574

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08568

1. DECEASED-NAME (Type or print) ESTELLE KAYE GILBERT			2a. DATE OF DEATH Month 6 Day 7 Year 69			2b. HOUR 1:50 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 3/21/19		6. AGE (In years last birthday) 30 YRS.	
7a. BIRTHPLACE (State or foreign country) NY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD		13b. COUNTY MONT.		13c. CITY OR TOWN SIL. SPR.		13e. STREET AND NUMBER 10505 INGLEBY ST.	
14. FATHER'S NAME First SAMUEL Middle HERMAN Last —			15. MOTHER'S MAIDEN NAME First WINNIE Middle — Last —				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 099-18-3548		17. INFORMANT CAROL ANN GILBERT Address 2445 LITTLE ROCK RD SILVER SPRING, MD			
18. CAUSE OF DEATH (Enter only one cause per Part 1. Death was caused by IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO MYOCARDIAL INFARCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR. DUE TO, OR AS A CONSEQUENCE OF (b) — 1 HR. DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE 2 MOS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6/5/69 to 6/7/69 , that (I) (we) last saw the deceased alive on 6/5/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David Goldenberg MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/7/69	
22d. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG				22e. ADDRESS 9801 GEORGIA, SILVER SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-9-1969		23c. NAME OF CEMETERY OR CREMATORY NATHA MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FALLS CHURCH VA.	
24. FUNERAL DIRECTOR CONDORELLA FUNERAL HOME				ADDRESS 4217 9TH ST. N.W.		25a. REC'D BY REGISTRAR JUN 10 1969	
				25b. REGISTRAR'S SIGNATURE Orlando D. Dudge			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08575

08569

1 DECEASED NAME (Type or print) RUSSELL, Emmitt			First Middle Last			2a DATE OF DEATH Month Day Year JUNE 15 1969			2b HOUR 12:18AM		
3 SEX MALE			4 RACE NEGRO			5 DATE OF BIRTH May 14, 1899			6 AGE (In years last birthday) 79 YRS.		
7a BIRTHPLACE (State or foreign country) BRUNSWICK CO, VA			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md		
10 CITY OR TOWN OF DEATH WHEATON, Md			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNIVERSITY NURSING HOME			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ITINERANT			12b KIND OF BUSINESS OR INDUSTRY		
13a USAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington D.C.			13b COUNTY 13c			13d INS DE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 1117-7th Street, N.E.		
14. FATHER'S NAME First Middle Last George Gillis			15 MOTHER'S MAIDEN NAME First Middle Last Amy Goodridge			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO			16b SOCIAL SECURITY NO		
17 INFORMANT Lillian Gillis - 1117-7th St N.E.			Address Goodridge			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral aneurysm 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cancer of prostate											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 8, 1969 to 6/14, 1969 , that (I) (we) last saw the deceased alive on 6/14, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Myron L. Harrison			DEGREE MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c DATE SIGNED 6/15/69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 6-19-69			23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery			23d LOCATION (City or Town) (County) (State) Suitland, Maryland		
24 FUNERAL DIRECTOR John T. Rhines Company Funeral Home 3015 12th Street, N.E., Wash. D.C.						25a REC'D BY REGISTRAR JUN 18 1969			25b REGISTRAR'S SIGNATURE Charles Judge		

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1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08570

CERTIFICATE OF DEATH

08570

1. DECEASED-NAME (Type or print) Katherine M. Gilson			2a. DATE OF DEATH Month June Day 29 Year 1969			2b. HOUR 7:30 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7/25/14		6. AGE (in years last birthday) 54 YRS.	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2804 Jutland Rd.		14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT John F. Gilson-2804 Jutland Rd., Kensington, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (b) metastasis to both frontal lobes DUE TO, OR AS A CONSEQUENCE OF (c) of cerebrum & liver							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Tuesday, 1969 , to June 29, 1969 , that (I) (we) last saw the deceased alive on June 28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael R. DoBridge				22c. DATE SIGNED June 29, 1969			
22d. PHYSICIAN'S NAME (Type) Michael R. DoBridge				22e. ADDRESS 9801 Georgia Ave., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE July 1, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc., Silver Spring, Maryland		25a. REC'D BY REGISTRAR 3 1969		25b. REGISTRAR'S SIGNATURE William E. Pumphrey			

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xxx

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
08577																							
CERTIFICATE OF DEATH																							
1 DECEASED NAME (Type or print)			First CHARLES			Middle H			Last GOOBY			2a. DATE OF DEATH Month 6			Day 20			Year 69			2b HOUR 5 45 P. M.		
3 SEX MALE			4 RACE WHITE			5. DATE OF BIRTH April 12, 1898			6 AGE (In years last birthday) 71 YRS			IF UNDER 1 WAR MONTHS			IF UNDER 24 HRS DAYS			IF UNDER 24 HRS HOURS			IF UNDER 24 HRS MIN		
7a BIRTHPLACE (State or foreign country) MASS.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery														
10 CITY OR TOWN OF DEATH BETHESDA			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROSS LANE N.H.S. CON. CENTRE			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Pool Cutter Atten			12b KIND OF BUSINESS OR INDUSTRY Martins														
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY 135			13c CITY OR TOWN Baltimore			13d INSURE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 5305 Liberty Heights Avenue											
14 FATHER'S NAME James Gooby			First Middle Last			15 MOTHER'S MAIDEN NAME Elizabeth James			First Middle Last														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes			(If yes give war or dates of service) W.W.I			16b SOCIAL SECURITY NO 215-01-5469			17 INFORMANT Mrs. Katherine M. Gooby			Address 5305 Liberty Heights											
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Independent pneumonia 477 DUE TO, OR AS A CONSEQUENCE OF (b) cerebrovascular accident / insufficient DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis 1 year chronic												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)						21f LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 11/2, 1969, to 6/20, 1969, that (I) (we) saw the deceased alive on 6/18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b SIGNATURE James Gooby, M.D.			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/>			MED D-RECTOR <input type="checkbox"/>			STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 6/20/69								
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE June 23, 1969			23c NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery			23d LOCATION (City or Town) (County) (State) Pikesville, Maryland														
24 FUNERAL DIRECTOR Loring Byers Chapel 8728 Liberty Road 21133			ADDRESS			25a REC'D BY REG STRAR DATE JUN 24 1969			25b REGISTRAR'S SIGNATURE L. Byers														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08578

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08572

1. DECEASED-NAME (Type or print) <i>Frances J. Goodenham</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>15</i> Year <i>1969</i>			2b. HOUR <i>11:45</i> AM			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>8/24/87</i>		6. AGE (In years last birthday) <i>81</i> YRS		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Canada</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Canada</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Canada</i>		13b. COUNTY <i>York Co.</i>		13c. CITY OR TOWN <i>Toronto</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>61 Highbourne Rd</i>	
14. FATHER'S NAME First <i>Daniel</i> Middle <i>Williams</i> Last <i>Ford</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i></i> Last <i>Ford</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i></i> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT <i>Daughter Mary Ellen Ch. Ch. Md</i> Address <i>2807 Daniel St</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral ischemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>June</i> Day <i>14</i> Year <i>1969</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>June 13, 1969</i> , to <i>6-15, 1969</i> , that (I) (we) last saw the deceased alive on <i>June 14, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Edward J. Richards</i> M.D. DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>6-15-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>EDWARD J. RICHARDS, M.D.</i>				22e. ADDRESS <i>10110 Georgia Ave Shuwp Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>6-16-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Toronto, York Co. Ontario</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY,</i>				755 ADDRESS <i>Wisconsin Ave</i>		REC'D BY REG. STRAR <i>UN 19 1969</i>		25b. REG. STRAR'S SIGNATURE <i>Charles J. Gault</i>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>08579</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>08573</div>										
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR	
SARA - McMahan Goodman						<input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> ESTIMATED <input type="checkbox"/> JUNE 8 1969			<input checked="" type="checkbox"/> 5:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR		8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR
Fe.	W.	6/8/95	74 YRS	MONTHS DAYS		HOURS MIN		Month Day Year June 8 1969		<input checked="" type="checkbox"/> 5:30 PM
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH	
South Carolina			U.S.A.						Montgomery Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda.			GROVER Nursing Home							
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	
Md.			Pr. George			Hillcrest.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO	
Jesse			Robert McMahan			Dora S. Callas			(Yes no, or unknown) (If yes give war or dates of service)	
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mrs. Dora G. Craig			5110 28th Pkwy, Hillcrest Hts.			PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.			2 weeks? years	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			21d. LOCATION (Street or R.F.D. No City or Town County State)	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED June 8, 1969			23a. B. RIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE	
24. FUNERAL DIRECTOR Cunningham Mountcastle Woodbridge, Va.			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			26. NAME OF CEMETERY OR CREMATORY POKICK CEMETERY			27. LOCATION (City or Town) (County) (State) LORTON FAIRFAX CO VA.			28. REC'D BY REGISTRAR JUN 10 1969	



1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Elizabeth		11.	Griffith		June 21 1969			9 AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	Caucasian		08/04/94		74 YRS		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Baltimore, Md.	U.S.A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPAT ON (Kind of work done most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Chevy Chase	Bethesda Silver Spring		HOUSEWIFE		AT HOME				
13a. USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Wash. D.C.				Wash, D.C.		YES		2808 94th St. N.W.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S M A DEN NAME -first		Maiden		
John				Nightman	Etha White				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		578-07-8371		WILLIAM D. GRIFFITH - SAME		17s. #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) INTRACRANIAL METASTASES									
1621 DUE TO, OR AS A CONSEQUENCE OF									
(b) CARCINOMA OF LUNG									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
URINARY TRACT INFECTION AND SEPTICEMIA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from MAY 1, 1969, to JUNE 21, 1969, that (I) (we) last saw the deceased alive on JUNE 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		M.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
N. Thomas Connolly						JUNE 21, 1969			
22d. PHYSICIAN'S NAME (Type)		N. THOMAS CONNALLY		22e. ADDRESS		1835 EYE ST. N.W. WASH. D.C.			
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		6/24/69		EPIPHANY CHURCH CEM.		FORESTVILLE, P.G., MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE			
JOSEPH CAWLER'S SONS		5130 WISCONSIN AVE		JUN 26 1969		J. Charles Judge			
		WASHINGTON, D.C.							

7769

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

08581

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08575

1. DECEASED-NAME (Type or print)		First Lee	Middle Emory	Last Griffith	2a. DATE OF DEATH Month Day Year June 29, 1969		2b. HOUR 1:35a M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 6-28-69		6 AGE (in years last birthday) — YRS		7 UNDER 1 YEAR MONTHS DAYS 10 3
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington San & Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, admission) STATE Md.		13b COUNTY P.G.		13c CITY OR TOWN Seat Pleasant		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 22 Cindy Lane
14 FATHER'S NAME First Middle Last Emory Lee Griffith		15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Mentory Moreland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		(If yes give war or dates of service)		6b SOCIAL SECURITY NO None		17 INFORMANT Mothers record		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anoxia + atelectasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State
22a I certify that (I) (this hospital) attended the deceased from <u>6-28</u> , 19 <u>69</u> , to <u>6-29</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-29</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <u>Herbert M. Solomon MD</u>				DEGREE ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
22d PHYSICIAN'S NAME (Type) <u>Herbert M. Solomon</u>				22e ADDRESS <u>Seabrook, Md</u>				
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE <u>July 1, 1969</u>		23c NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d LOCATION (City or Town) <u>Colmar Manor</u>		(County) <u>P. G.</u> (State) <u>Md.</u>
24 FUNERAL DIRECTOR <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a REC'D BY REGISTRAR DATE <u>JUL 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

08582

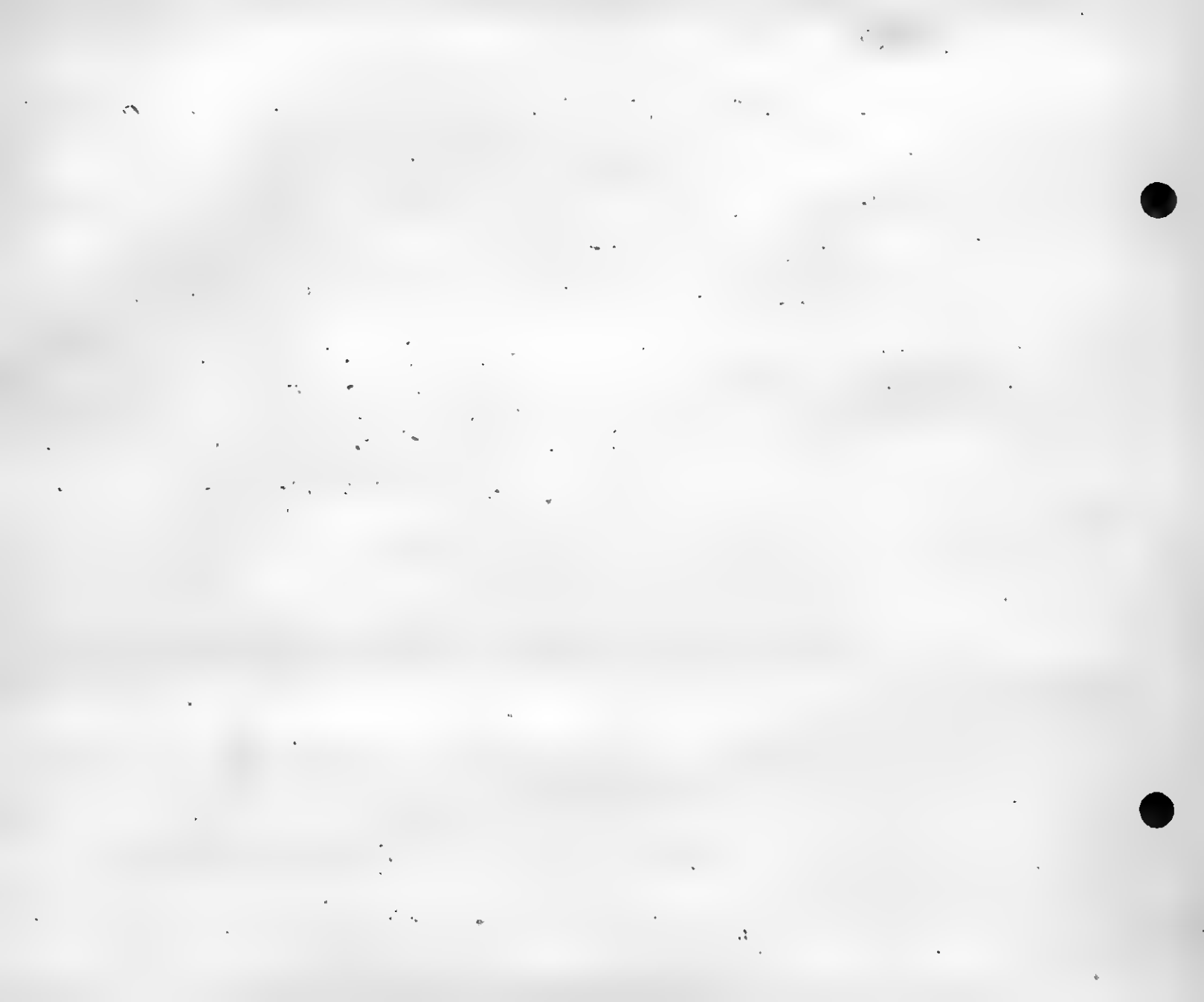
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) EUGENE SHILLER GUILD			2a. DATE OF DEATH Month JUNE Day 15 Year 1969			2b. HOUR 1:10 M	
3. SEX M		4. RACE W		5. DATE OF BIRTH 1-1-1896		6. AGE (In years lost birthday) 73 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONT.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CEDAR HAVEN		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONT		13c. CITY OR TOWN TAK. PK MD		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 7300 TAK. PARK RD		13f. CITY OR TOWN BALTIMORE		13g. STATE MD		13h. ZIP CODE 21201	
14. FATHER'S NAME First WILLIS E Middle GUILD Last GUILD			15. MOTHER'S MAIDEN NAME First EMMA Middle SCHILLER Last GUILD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES (If yes give war or dates of service) NAVY		16b. SOCIAL SECURITY NO.		17. INFORMANT JOHN A BEAULIEU 7310 FLOWER AVE TAKOMA PARK MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION ACUTE MYOCARDIAL INFARCTION 1109 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 10 YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from FEB , 1969, to JUNE 15 , 1969, that (I) (we) last saw the deceased alive on MAY 26 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert L. Friedman		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED JUNE 15 1969	
22d. PHYSICIAN'S NAME (Type) Robert L. Friedman MD		22e. ADDRESS 7733 MARYLAND AVE NW WASHINGTON DC 20012					
23a. BURIAL, CREMATION, REMOVAL (Specify) June 18-1969		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Charles Judge		ADDRESS 254 Carroll St		25a. REC'D BY REGISTRAR JUN 19 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

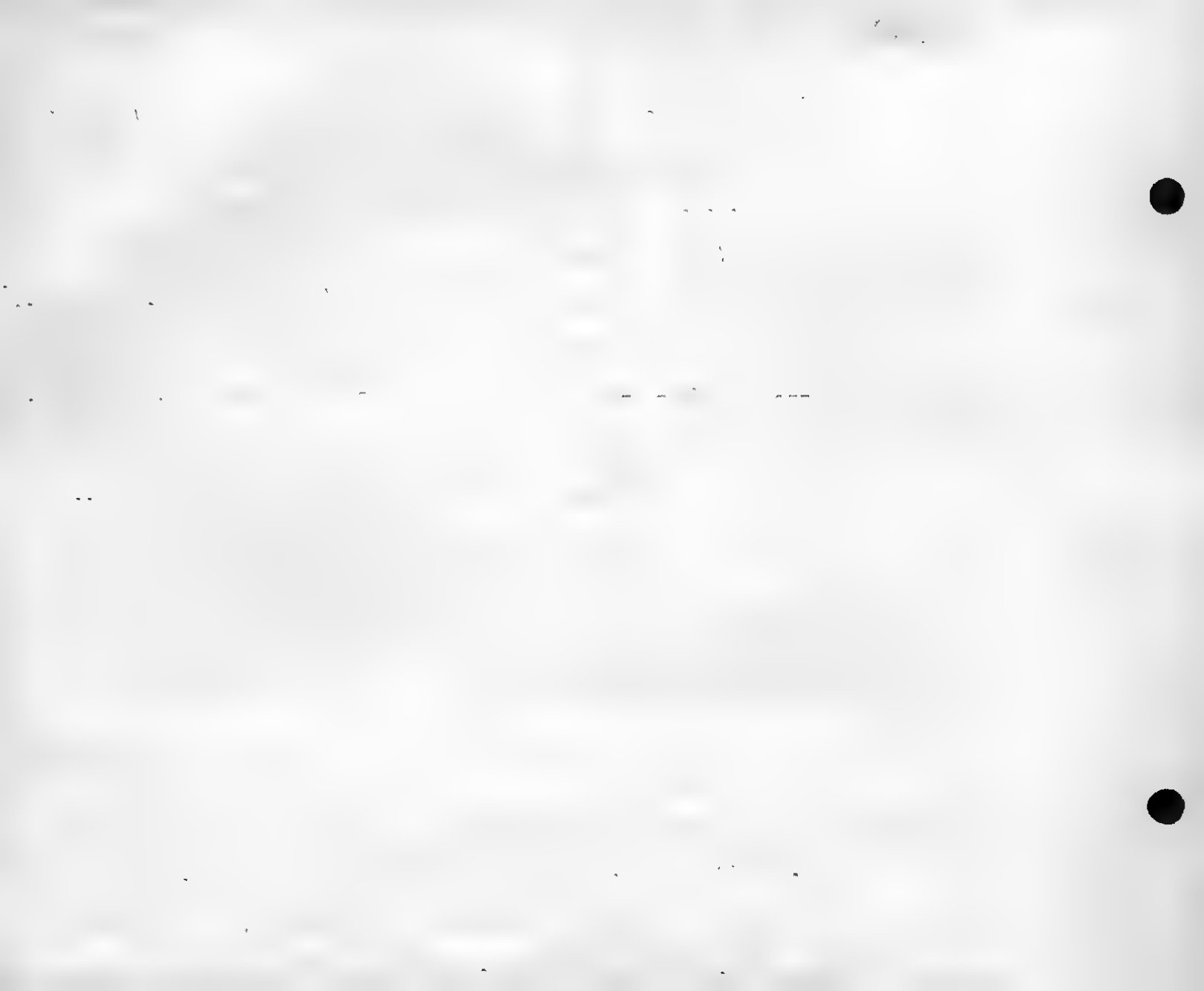
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16. MEDICAL CERTIFICATE ON
CLEARED WITH MEDICAL EXAMINER DE READ 150 AM.



1. DECEASED NAME (Type or print) Arline K. Hall		2a. DATE OF DEATH Month June Day 8 Year 1969		2b. HOUR 5:00 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 27, 1888	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (in years last birthday) 80 YRS.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10406 Insley Street		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admision) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME First George Middle Kingsley Last Kingsley		15. MOTHER'S MAIDEN NAME First Julia Middle Susan Last Rodington		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16b. SOCIAL SECURITY NO. 579-60-3471		17. INFORMANT Margaret Padd - 10406 Insley St., S.S., Md.		18. ADDRESS 10406 Insley St., Sil. Spr., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 15.37 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic CA cecum DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 8 mo.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASHD					
19a. DATE OF OPERATION 12/20/1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA cecum		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 23, 1969 to June 8, 1969 , that (I) (we) last saw the deceased alive on May 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE John D. Griswold M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED June 8, 1969	
22d. PHYSICIAN'S NAME (Type) John D. Griswold, M.D.				22e. ADDRESS 4830 11 Street, N.W., D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 11, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION (City or Town) (County) (State) Switzland, Maryland		24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc., Silver Spring, Md.		25a. RECEIVED BY REGISTRAR JUN 12 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge					



08584

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
BEATRICE		A.		HALLORAN	June Month 6, Day Year 69		2 40 P.M.	
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR	
FEMALE	WHITE		12/2/94		74 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Mass.		U.S.A.				MONTGOMERY, Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING		HOLY CROSS HOSP.		Retired - G.A.O.		US Gov't.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Md.		Mont.		SilverSpr.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10820 Ga. Ave.
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
John H. Doherty		Delia - Seymour						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No		---		Charles E. Halloran, Jr., Olney, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction, recurrent.</u>								21 hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u>								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
<u>G.I. bleeding secondary to duodenal ulcer</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
6/3/69		Complete heart block		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>5/30</u> , 19 <u>69</u> , to <u>6/6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/6</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
<u>Benne G. Bandler M.D.</u>						6/6/69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
BENNE G. BENDLER, M.D.		10820 Georgia - Wheaton, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		6/9/69		Mt. Olivet Cemetery		Washington, D.C.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Joseph Gawler's Sons, Washington, D.C.		JUN 12 1969		<u>Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



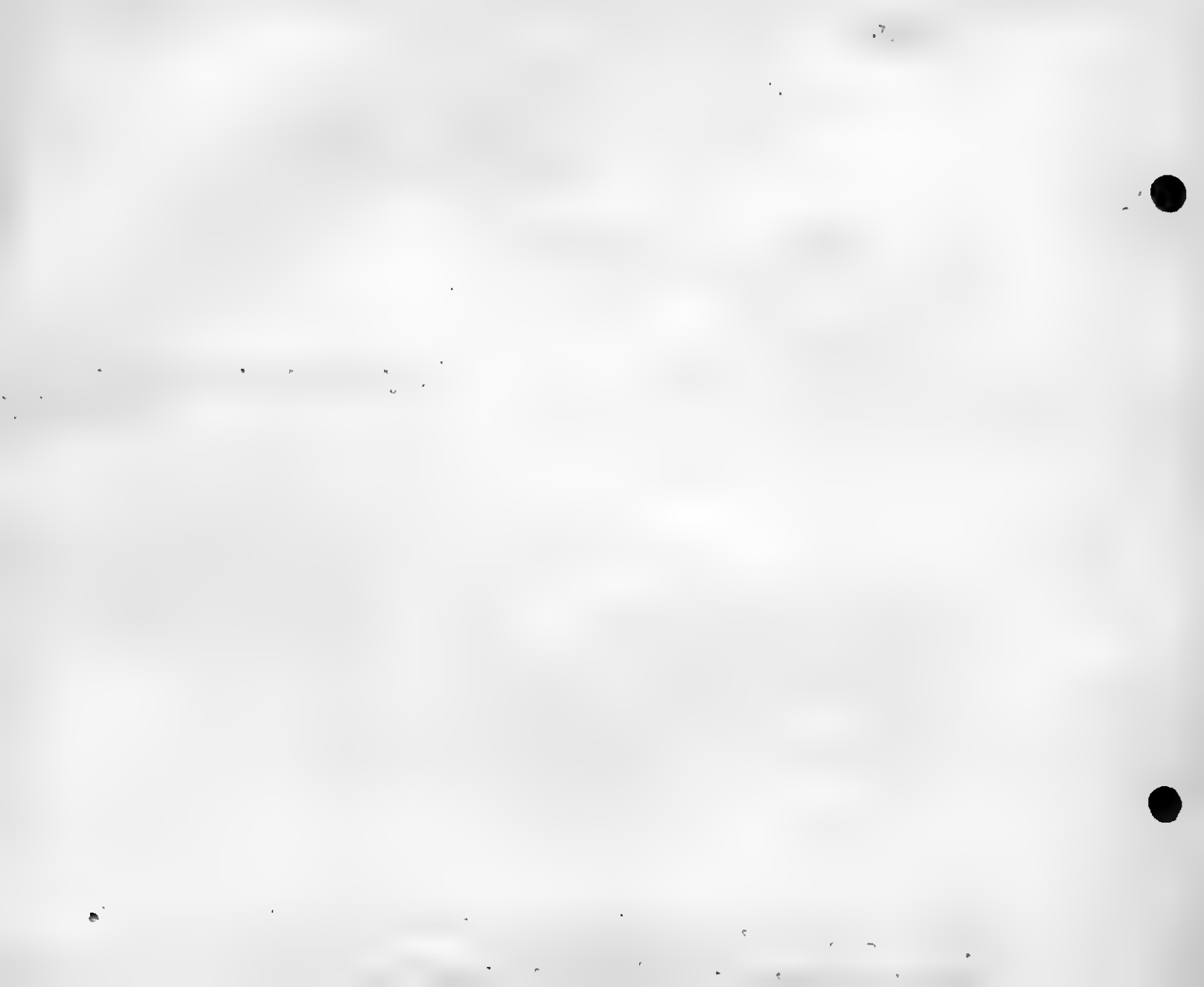
08585

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR	
MARJORIE D. HANSEN					6 Month 23 Day 69 Year		0455M	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
F	CAUC.		DEC 3, 1897		71 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
MINN.		USA				MONTGOMERY Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING		CARPINE HILL 1909 HANOVER ST.		CLAIMS EXAMINER		V.A.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, I.A. 15?		13e STREET AND NUMBER
MD.		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1021 N. NOYES DR.
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
NEWTON				DE FOREST	ANNA			KENNEDY
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
NO		NO		216-44-2952-MI		Paul J. Hansen, Jr. 504 Phil. Ave., Silver Spring, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EMPHYSEMA, PULMONARY								
492X DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								
(b) Myocardial Failure								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
MALNUTRITION								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
NONE		N.A.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		N.A.		
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
<input type="checkbox"/> OR COMMENCEMENT OF DEATH (If a later, notify medical examiner)		HOUR A.M. Month Day Year						
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		City or Town		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or RFD No		County State		
22a. I certify that (I) (the hospital) attended the deceased from 21 JUNE, 19 69, to 23 JUNE 19 69, that (I) (we) saw the deceased alive on 21 JUNE 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)				
Donald B. Doty, M.D.		23 JUNE 69		DONALD B. DOTY, M.D.				
				22e ADDRESS				
				1909 HANOVER ST., SILVER SPRING				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		June 30, 1969		Arlington National Cemetery		Arlington, Virginia		
24 JUNE DIRECTOR		24b JUNE DIRECTOR		25a REC'D BY REG STRAR		25b REG STRAR'S SIGNATURE		
C. Glen Carter		C. Glen Carter		JUL 2 1969		C. Glen Carter		
Warner E. Pumphrey, Inc. Silver Spring, Md.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

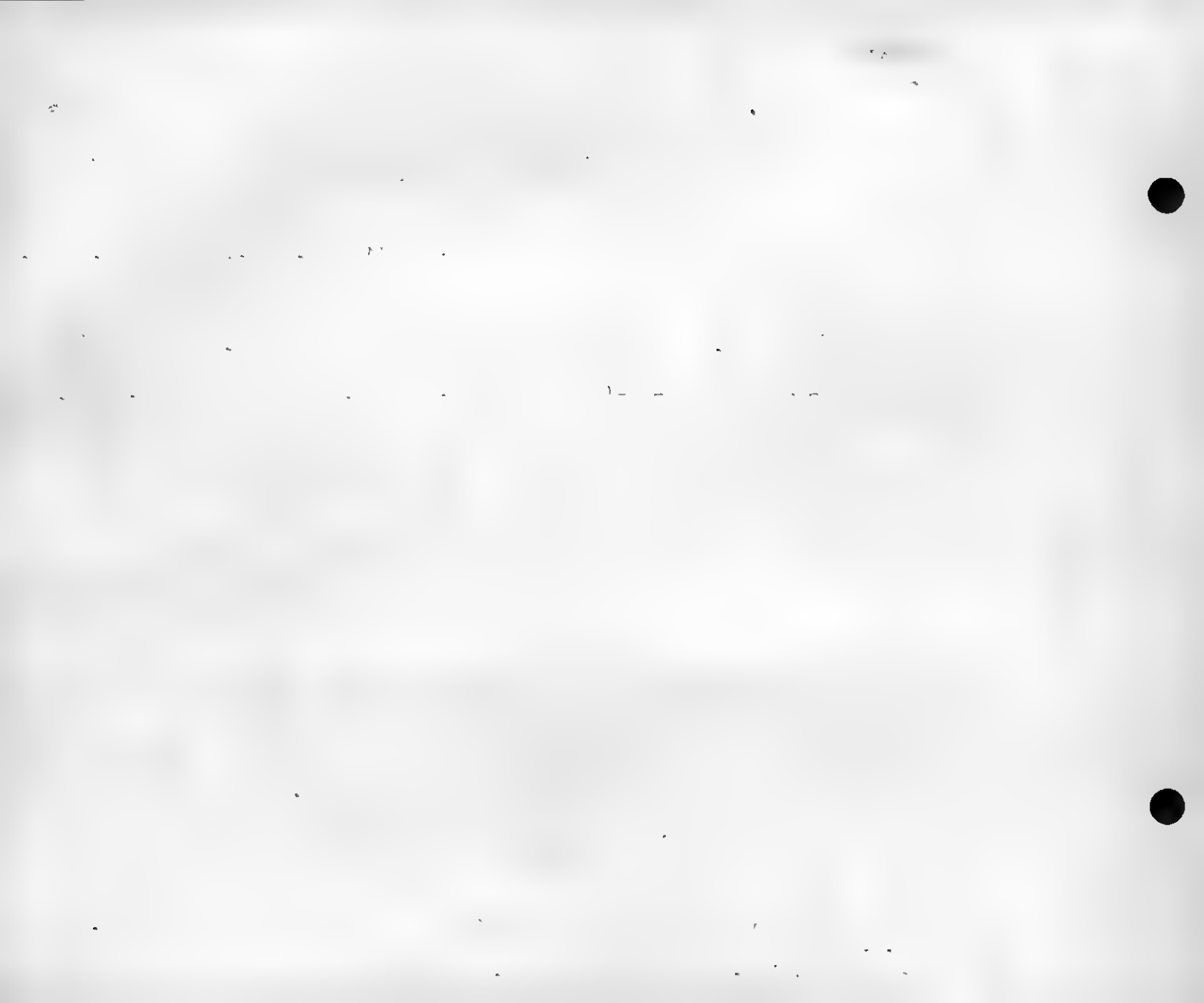


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print) ADAM C HARRIS												2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 30 Year 1969		2b HOUR 9:45					
3 SEX MALE		4 RACE W		5 DATE OF BIRTH 11/1/101		6 AGE (In years last birthday) 67 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		2c DATE PRONOUNCED DEAD Month 6 Day 30 Year 1969		2d HOUR 9:45					
7a BIRTHPLACE (State or foreign country) N.C.				7b CIT ZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH MONTECOMERY							
10. CITY OR TOWN OF DEATH SILVER SPRING				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) HOLY CROSS HOSP. East Kus. Mar. Geo. Wash. Univ.				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)				12b. KIND OF BUSINESS OR INDUSTRY							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.				13b COUNTY MONTECOMERY S.S.				13c CITY OR TOWN SILVER SPRING				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET AND NUMBER 8715 First Ave #1508			
14 FATHER'S NAME First Francis Middle S. Last Harris				15 MOTHER'S MAIDEN NAME First Connie Middle C. Last Coghill															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOCIAL SECURITY NO 577-28-1537				17 INFORMANT ADDRESS Frank S. Harris, 9109 Bradford Rd., Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage 887X DUE TO, OR AS A CONSEQUENCE OF (b) Massive intracranial hemorrhage due to DUE TO, OR AS A CONSEQUENCE OF (c) fall at home Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month Day, Year 6-24 1969				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased fell at home											
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f LOCATION Street or R.F.D. No 8715 First Ave. City or Town Silver Spring County Montg. State Md.											
22a. I certify that I took charge of the remains described above, held at death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED July 1, 1969							
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, Town or County)											
23a BURIAL CREMATION, REMOVAL (Specify) Burial				23b DATE July 5, 1969				23c NAME OF CEMETERY OR CREMATORY Elmwood Cemetery				23d LOCATION (City or Town) (County) (State) Henderson Vance, No. Carolina							
24a FUNERAL DIRECTOR G. Carter				24b ADDRESS 8434 Georgia Avenue				25a REC'D BY REG. STRAR JUL 7 1969				25b REGISTRAR'S SIGNATURE 1071...							
24c ADDRESS Warner E. Pumphrey, Inc., Silver Spring, Md.																			



08587

CERTIFICATE OF DEATH

08581

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u>				d. STREET ADDRESS <u>10908 New Hampshire Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>Harris</u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1969</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1892</u>	9. AGE (In years last birthday) <u>77</u> yrs	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>19</u> M. n.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>215-48-8511</u>		17. INFORMANT <u>Mrs. Sylvia Kleinberger (Same as #8)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic Renal Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 wks</u> <u>4 YRS.</u> <u>4 YRS.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pyelonephritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May, 1969</u> to <u>June 14, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 13, 1969</u> , and that death occurred at <u>6:45 AM</u> from causes and on the date stated above							
22a. SIGNATURE <u>Raymond T. Benack</u>				22b. DATE SIGNED <u>6/14/69</u>		22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack, M.D.</u>	
22d. ADDRESS <u>4115 Colie Drive, Silver Spring</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 16-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Royal Palm Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>St. Petersburg, Florida</u>	
24. FUNERAL DIRECTOR <u>Donald M. Stein</u>				25a. REC'D BY REGISTRAR <u>JUN 17 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Hebrew Memorial Funeral Home St. NWN Wash. D.C.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

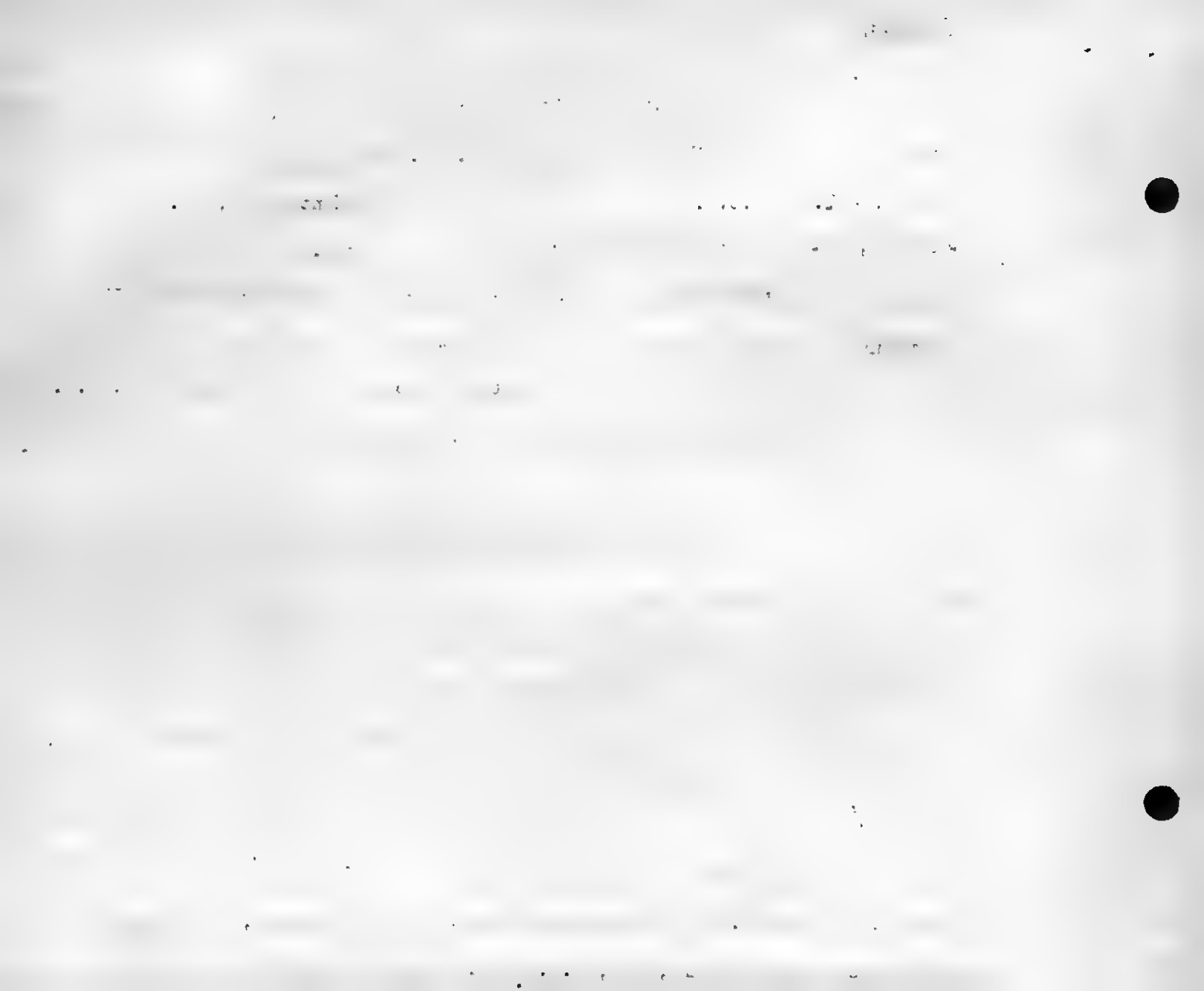
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08588										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08582																													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																																	
1. DECEASED NAME (Type or Print)										2a. DATE KNOWN OF DEATH										2b. HOUR																													
First Middle Last										ESTIMATED MONTH DAY YEAR										HOUR																													
Joseph F Haskins										June 6 8 1969										4:35 PM																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)																			
M										Negro										4-25-47										22 YRS																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. COUNTY OF DEATH																			
										U.S.A.										NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										Montgomery Md																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																			
Bethesda										Potomac River Spider Island																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER									
Va.										Fairfax										Falls Church										NO										2752 Annapondale Rd.									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																							
First Middle Last										First Middle Last																																							
F. HASKINS SR.										Florence Green																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																			
										226-62-7580										Joseph Haskins, Sr.										Salem 113																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 1 DEATH WAS CAUSED BY:																																																	
IMMEDIATE CAUSE (a)										Drowning										5 min																													
DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF																													
(c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																													
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS PRIMA CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH										21b. TIME OF INJURY Month Day, Year										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
PRIMA CAUSE OF DEATH <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>										4 PM 6/8/1969										Swimming in River & sank.																													
21d. INJURY OCCURRED										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION (Street or R.F.D. No City or Town County State)																													
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										Potomac River										Spider Island. Bethesda. Montgomery Md.																													
22a. I certify that I took charge of the remains described above, held on										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:																																							
										Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER										22b. DATE SIGNED																													
EXAMINER'S NAME (Type)										M.D.										ASSISTANT MEDICAL EXAMINER																													
John S. Ball																				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																													
																				ADDRESS (Street, city, town, or county)																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
F. H. K. + Y. L. M. M. M.										K. F. H. M. M.										JUN 16 1969										Charles Judge																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 08589 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08583 </div> <div style="display: flex; justify-content: space-between;"> Inter 3#13a, bc, e, Film 4414 7/11/69 CERTIFICATE OF DEATH </div>											
1 DECEASED NAME (Type or print) Sarah Kinzie Havemeyer						2a DATE OF DEATH Month June Day 28 Year 1969			2b HOUR 2:45 AM		
3 SEX Female		4 RACE White		5. DATE OF BIRTH Oct. 18. 1881			6 AGE (in years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS 1 DAYS 1 HOURS 1 MIN 1		
7a BIRTHPLACE (State or foreign country) Chicago, Ill.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery, Co. Md					
10 CITY OR TOWN OF DEATH Bethesda, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Westwood Retirement Home			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY At Home			
13a USUAL RES DENCE (Where deceased lived, if institution Residence before admission), STATE Maryland D.C.		13b. COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 201 Mass. Ave. NW 5101 Ridgefield Rd.			
14 FATHER'S NAME First Arthur Middle Magill Last Kinzie				15 MOTHER'S MAIDEN NAME First Caroline Middle Gilbert Last Wilson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b SOCIAL SECURITY NO.		17 INFORMANT Address Gertrude Thomas 4540 MacArthur Blvd. N.W. DC							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1956 , to June 28, 1969 , that (I) (we) last saw the deceased alive on June 27, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.											
22b SIGNATURE Alban W. Eger M.D.				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 6/28/1969			
22d. PHYSICIAN'S NAME (Type) Alban W. Eger				22e ADDRESS 1801 Eye St. N.W., Washington, D.C.							
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b DATE June 28. 69		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) Suitland, Maryland		(County)		(State)	
24 FUNERAL DIRECTOR Joseph Gawler Sons 5130 Wis. Ave. N.W. Wash. D.C.				ADDRESS		25a RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
						DATE JUL 2 1969					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08590

CERTIFICATE OF DEATH

08584

1. DECEASED-NAME (Type or print) Elgie Darius Hawkins			2a. DATE OF DEATH Month June Day 5 Year 1969			2b. HOUR 7:45 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8/24/91		6. AGE (in years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Merchant			12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Woodfield			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER RFD # 1, Gaithersburg	
14. FATHER'S NAME First James Middle Benjamin Last Hawkins			15. MOTHER'S M A D E N NAME First Annie Middle Belle Last Burns							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 212-16-8116			17. INFORMANT records Address Montgomery General Hospital, Olney, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Immunosuppressant Reaction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Herpes Zoster DUE TO, OR AS A CONSEQUENCE OF (c) Leukemia, Lymphatic APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days 15 days 10 years										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 6-5-1969 to 6-5-1969 , that (I) (we) last saw the deceased alive on 6-5-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jack Schumacher						ATTENDING PHYSICIAN DEGREE <input checked="" type="checkbox"/> MED <input type="checkbox"/> D RECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6-6-69		
22d. PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.						22e. ADDRESS 105 Russell Ave., Gaithersburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE June 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Upper Seneca Baptist			23d. LOCATION (City or town) (County) (State) Cedar Grove, Md.		
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.						25a. REC'D BY REGISTRAR June 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

4331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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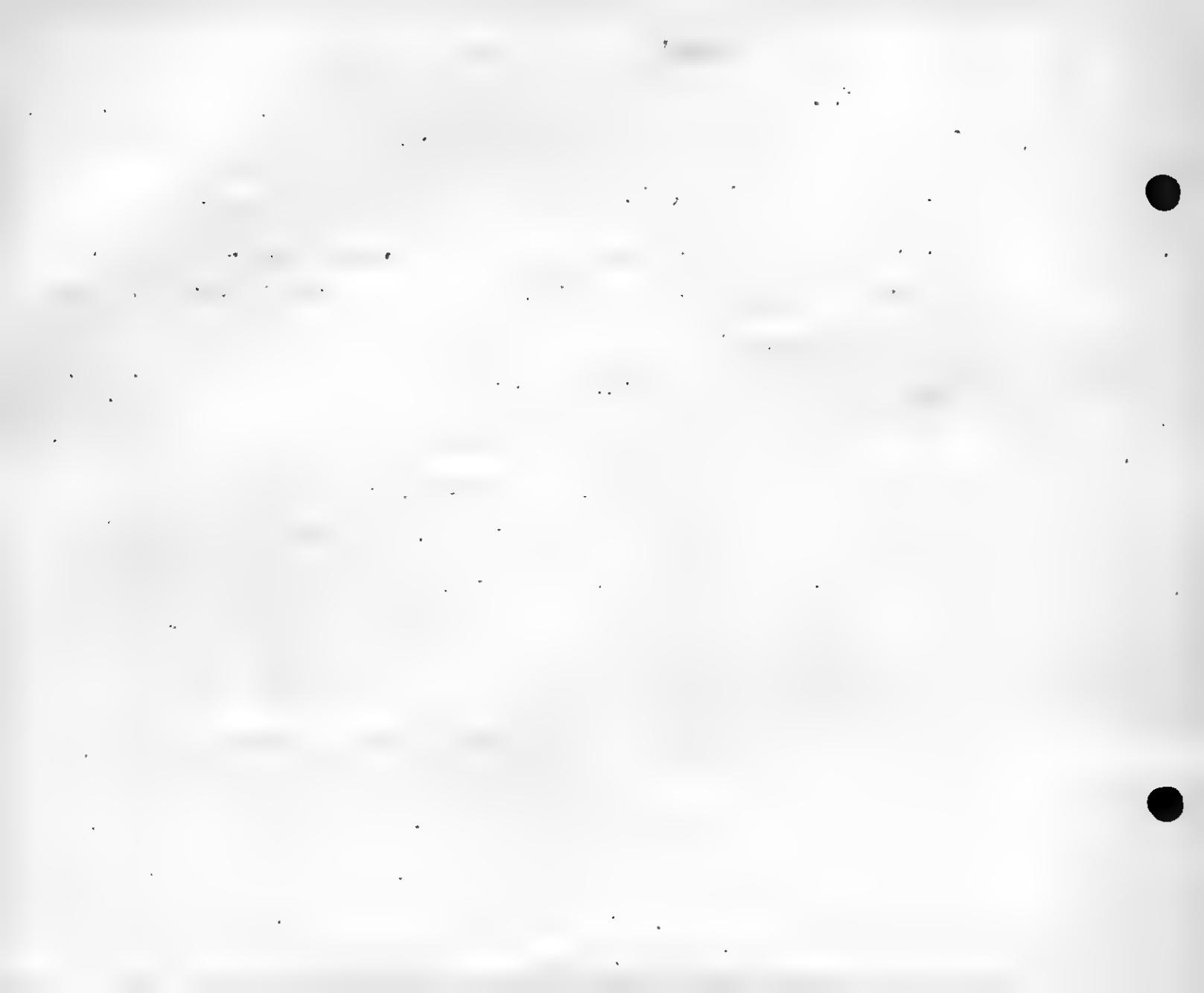
Items 1, 2, 14 & 17
Film 414 7/15/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08591 CERTIFICATE OF DEATH

08585

1. DECEASED-NAME (Type or print) <u>MARY</u> First Middle Last			2a. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>69</u>			2b. HOUR <u>5:30</u> M	
3. SEX <u>FEMALE</u>		RACE <u>White</u>		5. DATE OF BIRTH <u>7/8/99</u>		6. AGE (in years lost birthday) <u>69</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>MINN.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S. (U.S.)</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE - ADULT</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <u>MD.</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>SILVER SPRING</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>8809 READING ROAD.</u>		14. FATHER'S NAME First <u>Robert</u> Middle <u>UNKNOWN</u> Last <u>Sackett</u>		15. MOTHER'S MAIDEN NAME First <u>NETTIE</u> Middle <u>HOPKINS</u> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16b. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Heimer</u> <u>AMOS K. HEIMER</u> Address <u>8809 READING RD SILVER SPRING MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL ATHEROSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF <u>AND</u> (c) <u>MYOCARDIAL INFARCTION, ACUTE ANTERIOR</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> <u>2 YEARS</u> <u>5 DAYS</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>FATTY LIVER</u> <u>GENERAL ARTERIOSCLEROSIS, CHRONIC PYELONEPHRITIS, WITH HEPATOMEGALY</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 25, 1953</u> , to <u>6/18, 1969</u> , that (I) (we) last saw the deceased alive on <u>6/18, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James A. Roberts M.D.</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>6/18/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS M.D.</u>				22e. ADDRESS <u>8907 GEORGIA AVE. SILVER SPRING, MD.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6-21-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>ROCKVILLE MD.</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS</u> ADDRESS <u>1400 CHAPIN ST. N.W. WASH. D.C.</u>				25a. REC'D BY REGISTRAR <u>JUN 20 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



1

08592

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08586

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Joseph M Henning						Month	Day	Year	1214		
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER YEAR MONTHS		8. UNDER 24 HRS. HOURS M.N.	
male	white		11/24/1894			74 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wash DC		US				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross			Admin Assis			Essday		
13a. U.S.A. RESIDENCE (Where deceased admiss on) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md			Montgomery			Silver Spring				Meat Co. 10300 Tenbrook Dr	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Joseph Henning						Effie Stansburg					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
yes			W.W. I 578013569A			Lucy B. -wife			same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION					
						Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1969</u> to <u>June 17, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 13, 1969</u> , and that (my) (our) opinion of the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
<u>Edward J. Richards</u>						6-14-69					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
EDWARD J. RICHARDS, MD						9801 Georgie Ave. Silver Spring, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			6-17-69		Ft. Lincoln			Bladensburg, Maryland			
24. FUNERAL DIRECTOR						24a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis J. Collins						JUN 17 1969		<u>Charles J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4123
Cleared with Md. Coriam



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED WITH MEDICAL EXAMINER

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First PETER		Middle WESLEY		Last HICKS		2a DATE OF DEATH Month Day Year 6 12 69		2b HOUR M
3. SEX Male		4 RACE White		5 DATE OF BIRTH XXXX 4-27-88		6 AGE (In years lost birthday) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Va.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery				Md
1d CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Silver Sp.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 406 E. Melbourne Ave.		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										<u>Immediate</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Vascular Disease</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Diabetes Mellitus</u>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>June</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Bernard A. Fitzgerald</u> MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 6-12-69				
22d PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22e ADDRESS 217 UNIV. BLVD E, SILVER SPRING, MD								
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE 6/17/69		23c NAME OF CEMETERY OR CREMATORY Lawson Methodist		23d LOCATION (City or Town) Regnum		(County) Va		State
24 FUNERAL DIRECTOR <u>First Funeral Parlor</u>		ADDRESS <u>Bay 709 Culp</u>		25a REC'D BY REGISTRAR DATE JUN 17 1969		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

1729

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 8-54
30M REV 1/68

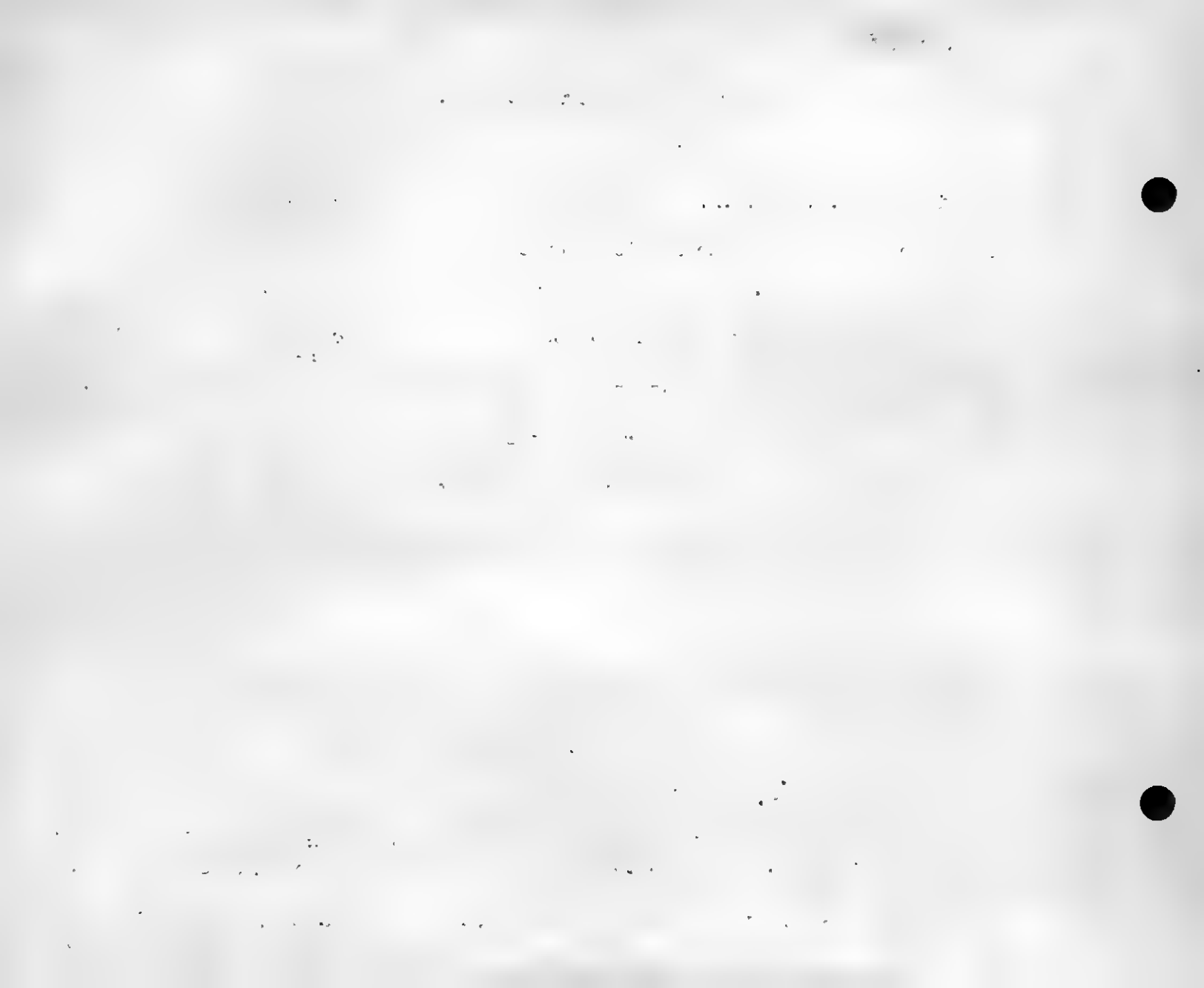
08594

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08588

1. DECEASED-NAME (Type or print) Samuel Shorey Hollingsworth Jr.			2a. DATE OF DEATH Month June Day 18 Year 1969			2b. HOUR P 3:30 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3 February 1939		6. AGE (in years last birthday) 30 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Lawyer			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Clarksburg		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 118	
14. FATHER'S NAME First Middle Last Samuel Shorey Hollingsworth			15. MOTHER'S MAIDEN NAME First Middle Last Josephine Hefren							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 214-36-1314		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 1729 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Malignant Melanoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes Years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that Dr (this hospital) attended the deceased from 24 April , 19 69 , to 18 June , 19 69 , that Dr (we) last saw the deceased alive on 18 June , 19 69 , and that in Dr (our) opinion death occurred on the date and hour and from the causes stated above, Dr (we) (did) (do not) view the body after death.										
22b. SIGNATURE David A. Bray MD				22c. DATE SIGNED 19 June 1969						
22d. PHYSICIAN'S NAME (Type) David A. Bray, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014						
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE 6/21/69		23c. NAME OF CEMETERY OR CREMATORY St. Joseph		23d. LOCATION (City or Town) (County) (State) Buckeystown Fred. Md.				
24. FUNERAL DIRECTOR Constance C. Hilton Barnesville				25a. REC'D BY REGISTRAR JUN 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				



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4123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08595

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08589

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last John Henry Holsey			2a. DATE OF DEATH Month Day Year 6 9 1969			2b. HOUR 10:55 PM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH 5/14/75		6. AGE (In years last birthday) 94 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, OR INSTITUTION (if not in hospital give street address) Grossinger La. Mr. Name		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 9453 H. HOLSEY RD.		14. FATHER'S NAME First Middle Last John H. Holsey		15. MOTHER'S MAIDEN NAME First Middle Last Catherine Potts			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 217-10-9751		17. INFORMANT 9453 Holsey Rd. S. Linwood Holsey, Damascus, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC H. DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS 2 YRS 10 YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ARTERIOSCLEROTIC GANGRENE RT. LEG</u> 3 WKS.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>69</u> , to <u>June 9</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>June 9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <u>Ronald W. Barr</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED June 9, 1969	
22d. PHYSICIAN'S NAME (Type) RONALD W. BARR, M.D.				22e. ADDRESS 10401 OLD GEORGETOWN RD BETHESDA			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 12, 1969		23c. NAME OF CEMETERY OR CREMATORY Friendship Meth.		23d. LOCATION (City or Town) (County) (State) Damascus, Md.	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.				25a. REC'D BY REGISTRAR JUN 13 1969		25b. REGISTRAR'S SIGNATURE <u>J. L. ...</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

All had notified of death 6/14/69

08596

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08590

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Eleanor M. Howe</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>19</i> Year <i>1969</i>			2b. HOUR <i>3:45 A M</i>						
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>3/7/92</i>		6. AGE (In years last birthday) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>				
7a. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>						
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if in institution Res. dence before admiss. an) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Silver Spring</i>			13d. NO. DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First <i>Phillip Hardesty</i> Middle <i></i> Last <i></i>			15. MOTHER'S MAIDEN NAME First <i>Mary E.</i> Middle <i></i> Last <i>Sweeney</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of serv. ce.)				16b. SOCIAL SECURITY NO. <i>578-12-3526</i>		
17. INFORMANT <i>Eleanor Robertson</i>			18. ADDRESS OF INFORMANT <i>622 Mississippi Avenue Silver Spring, Md.</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO, OR AS A CONSEQUENCE OF <i>Cigarettes</i> (b) <i>Chronic Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF <i></i> (c) <i></i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <i></i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i> P.M. <i></i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>						
22a. I certify that (I) (this hospital) attended the deceased from <i>June 16, 1969</i> to <i>June 19, 1969</i> , that (I) (we) last saw the deceased alive on <i>June 18, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Robert T. Thibadeau</i>			22c. PHYSICIAN'S NAME (Type) <i>ROBERT T. THIBADEAU</i>			22d. ADDRESS <i>11,000 Old Orchard Rd Rockville, Md 20852</i>			22e. DATE SIGNED <i>June 19, 1969</i>			
23a. BURIAL (CREMATION, REMOVAL Specify) <i>Burial</i>			23b. DATE <i>June 21, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>			
24. FUNERAL DIRECTOR <i>Warner E. Phibbey, Inc.</i>			24a. ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>			25a. REC'D BY REGISTRAR DATE <i>JUN 23 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08597

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08591

CERTIFICATE OF DEATH

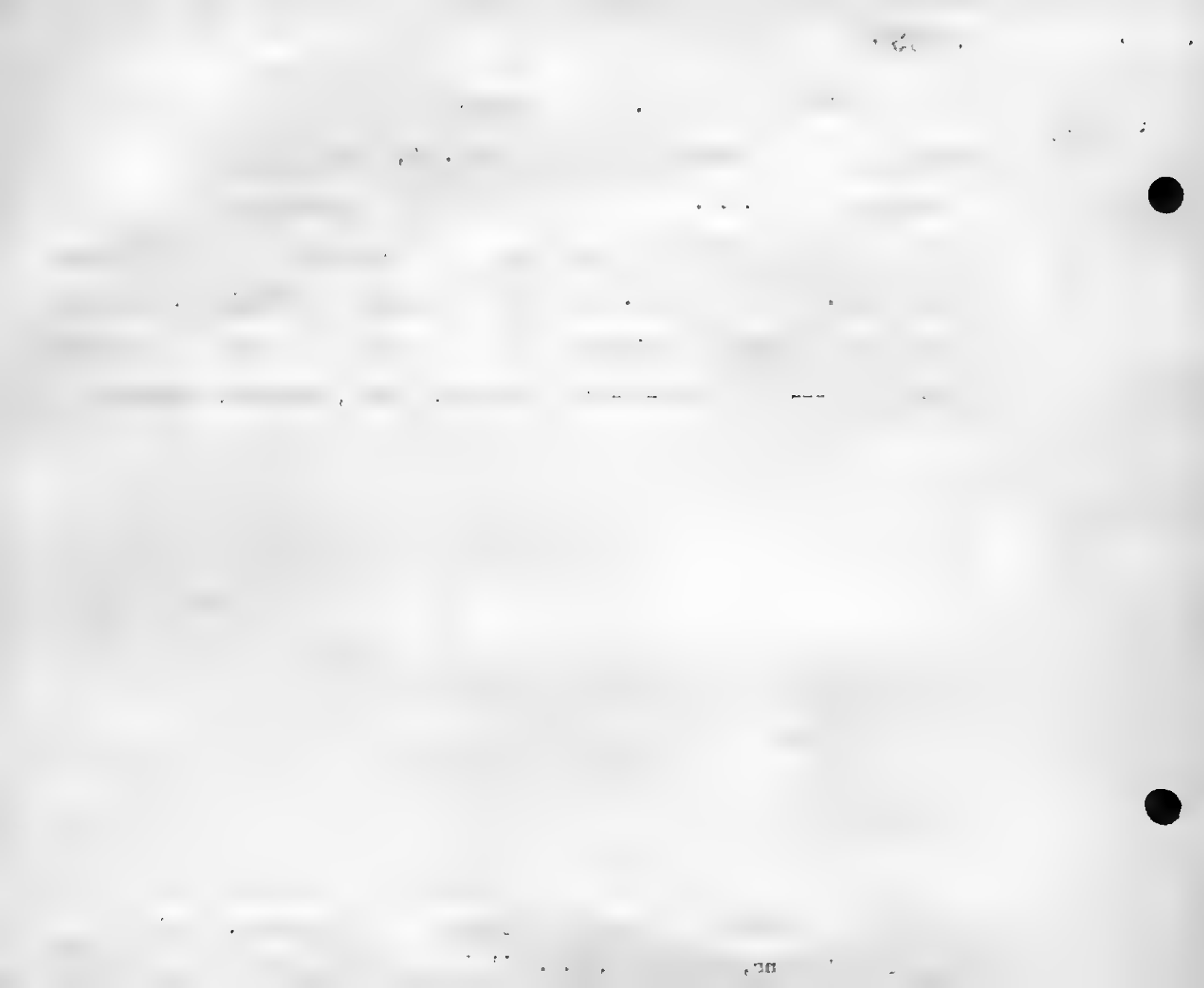
1 DECEASED NAME (Type or print) Carl M. Hudson			2a. DATE OF DEATH 6 Month 26 Day 69 Year		2b. HOUR 10 A M
3 SEX Male	4 RACE White	5. DATE OF BIRTH 6-9-1905	6 AGE (in years last birthday) 64 YRS	7. UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) WASH. D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Refrigerator-Fruit & Veg. Grocery	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE md.	13b. COUNTY Mont.	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3303 Winnett Road	
14 FATHER'S NAME First Middle Last THOMAS R. HUDSON		15 MOTHER'S MAIDEN NAME First Middle Last DOVIE CATHERINE HINES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW II		16b. SOCIAL SECURITY NO 217-32-0843		17. INFORMANT Daughter Judy Hollis Address 8107 15th. Ave. HYATTSVILLE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction 411 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 3 yrs					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 6/24 , to 6/26 , 19 69 , that (I) (we) last saw the deceased alive on 26 May 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Horace W. Bernnton		22c. DATE SIGNED 6/26/69		22d. PHYSICIAN'S NAME (Type) HORACE W. BERNNTON	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/30/69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.	
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, 5130 WILCONSHAW, WASHINGTON, DC		23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.		25a. REC'D BY REGISTRAR JUN 30 1969	
25b. REGISTRAR'S SIGNATURE J. G. Judge					

4310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08598		CERTIFICATE OF DEATH						08592		
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR	
Barbara			J. Hughes			JUNE 19 1969			4:30 P M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Caucasian		Sept. 17, 1884			84 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland			U.S.A.				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Kenwood			6004 Highland Drive			Housewife			At Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Montg.		Kenwood				6004 Highland Drive	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
William Butler Firoved			Mary Ann Shuffler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No			---		220-44-9227 Sadie F. Hughes, Daughter, Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, massive</u> <u>4911</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>13 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>3 1/2 hours</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1956</u> to <u>June 19, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 19, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Frank S. Bacon MD</u>				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>June 19, 1969</u>		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
FRANK S. BACON				2141 K. ST. N.W. WASH. D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6/23/69		Arlington National		Arlington, Virginia				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Joseph Gawler's Sons, 5130 Wisconsin Ave., NW				JUN 26 1969		<u>[Signature]</u>				



08599

CERTIFICATE OF DEATH

08593

1 DECEASED NAME (Type or print) John			First H.			Middle Humphreys			Last			2a DATE OF DEATH Month June Day 19 Year 1969			2b HOUR 4:31 PM		
3 SEX M			4 RACE Wh			5 DATE OF BIRTH June 25, 1894			6 AGE (In years last birthday) 74 YRS.			IF UNDER 1 YEAR MONTHS 7 DAYS 14			IF UNDER 24 HRS. HOURS 4 MIN 31		
7a BIRTHPLACE (State or foreign country) Texas			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery County Md								
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman			12b KIND OF BUSINESS OR INDUSTRY								
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MARYLAND			13b COUNTY Montgomery			13c CITY OR TOWN Silver Spring			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 220 Williamsburg Dr.					
14 FATHER'S NAME First Charles J. Middle J. Last Humphreys			15 MOTHER'S MAIDEN NAME First Mary Middle Elizabeth Last Vollentine														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b SOCIAL SECURITY NO. 578-01-2244			17 INFORMANT Address Clara L. Humphreys Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebral thrombosis, probably pontine															4 days		
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis															Several years		
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from June 15, 1969 , to June 19, 1969 , that (I) (we) last saw the deceased alive on June 19, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b SIGNATURE Bennet A. Porter, Jr.			22c DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22e DATE SIGNED June 19, 1969								
22d. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D.			22e ADDRESS 9301 Colesville Rd., Silver Spring Md.														
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE June 23, 1969			23c NAME OF CEMETERY OR CREMATORY Gate of Heaven			23d LOCATION (City or Town) (County) (State) Silver Spring Md.								
24 FUNERAL DIRECTOR Francis J. Hall			ADDRESS 500 University Blvd., W. Silver Spring, Md.			25a REC'D BY REGISTRAR JUN 23 1969			25b REGISTRAR'S SIGNATURE [Signature]								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4124

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> 08600 CERTIFICATE OF DEATH 08594 </div>										
1. DECEASED-NAME (Type or print) ALICE COFFROTH HUTSON						2a. DATE OF DEATH Month JUNE Day 10 Year 1969		2b. HOUR 7:15 PM		
3. SEX Female		4 RACE Caucasian		5. DATE OF BIRTH June 23, 1884		6. AGE (In years, last birthday) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7827 Aberdeen Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7827 Aberdeen Road	
14. FATHER'S NAME First Charles Middle -- Last Coffroth			15. MOTHER'S MAIDEN NAME First Ella Middle -- Last Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give year or dates of service) ---			16b. SOCIAL SECURITY NO 578-28-9721		17. INFORMANT Address J.M. Baker, Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arterio-sclerotic Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis of Old age APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 18 years										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1967 to June 10, 1969 , that (I) (we) last saw the deceased alive on June 10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Samuel Diener, M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/10/69				
22d. PHYSICIAN'S NAME (Type) SAMUEL DIENER				22e. ADDRESS 4201 Miam. Ave. N.W. Wash. D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/13/69		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION (City or Town) (County) (State) Rockville, Md.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.				25a. REC'D BY REGISTRAR 5130 Wisconsin Ave, NW		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 16 1969		



595-4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08601		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08595	
Item 13 Film 413 6/23/69 kk		CERTIFICATE OF DEATH					
1 DECEASED NAME (Type or print)		First		Middle		Last	
MARY		E.		JAGER			
3 SEX		4 RACE		5 DATE OF BIRTH		2a DATE OF DEATH	
FEMALE		WHITE		NOV. 26, 1886		Month Day Year	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
MD		U.S.A.				MONTGOMERY Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not at home, give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING		FAIRLAND NURSING HOME		Housewife		HOME	
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY, VILLS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD		Howard		CLARKSVILLE		13e STREET AND NUMBER 102 Thompson Dr.	
14 FATHER'S NAME		First		Middle		Last	
WILLIAM R THOMPSON							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address	
UNKNOWN		579-50-2766A		IRENE SEALING		CLARKSVILLE MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		uremia and Lobar Pneumonia				One week	
		Chronic nephritis				Two years	
		Ascending Cystitis				Two years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Hemophilia (left) several years					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from July 1967, to July 1969, that (I) (we) lost the deceased alive on July 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death (Death occurred at 5:30 P.M. 6/13/69)		22b SIGNATURE		22c DATE SIGNED			
J. M. Amberson, M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		6/13/69	
22d PHYSICIAN'S NAME (Type)		22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		6/16/69		St Pauls Lutheran		Fulton Maryland	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE	
Donaldson		Fulton		JUN 17 1969		Charles Judge	



4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08602

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08596

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Wilfrid		First	Middle	Lost	2a. DATE OF DEATH June 26 Day Year 1969		2b. HOUR 9:15 PM
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 15, 1913		6. AGE (In years last birthday) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Insurance		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Wm.		First		Middle		Lost	
15. MOTHER'S MAIDEN NAME Mary A. Perkin		First		Middle		Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII (If yes, list dates of service)		16b. SOCIAL SECURITY NO 093-05-5978		17. INFORMANT Nanette P. Jones		Address Same as item # 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Acute Myocardial Infarction							
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis							
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Atherosclerosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cachexia secondary to esoph. stenosis & surgery							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/27, 1960 to 6/20, 1969 , that (I) (we) last saw the deceased alive on 6/25, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen N. Jones M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 28, 1969	
22d. PHYSICIAN'S NAME (Type) Stephen N. Jones M.D.				22e. ADDRESS 809 Viers Mill Rd., Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/30/1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Rockville, Md.		1331 Rockville Pike		25a. REC'D BY REGISTRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08603

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08597

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> Month	Day	Year	2b HOUR	
MURKIN			B.	JOHNSON		ESTIMATED			<input type="checkbox"/> 6	3	1969	5 ^A M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)		7 UNDER 24 HRS		2c DATE PRONOUNCED DEAD			Month	Day	Year	2d HOUR
FEMALE	NEGRO	3-4-94	75 YRS		MONTHS DAYS HOURS MIN		JUNE 3			3	1969	5 ^A M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
Md.		U.S.A.				Montgomery			Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Beltsda			Suburban										
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER	
Md			Montgomery			Gaithersburg			YES <input type="checkbox"/> NO <input type="checkbox"/>			5112 Brookfield Rd.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
Thomas			Bowen			JARA			Bowen				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS				
No													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											3 days -		
2500 DUE TO, OR AS A CONSEQUENCE OF											years		
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost)											years -		
(b) Diabetes Mellitus.													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Generalized Arteriosclerosis.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		County	State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
22a. I certify that I took charge of the remains described above, held on			Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion										
Actual Signature			John B. Ball			M.D.			22b DATE SIGNED				
EXAMINER'S NAME (Type)						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
									June 3, 1969				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial			6/7/69			Mt. Zion Cemetery			Mt. Zion, Montg Md				
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE				
Robert L. Suonden			Rockville, Md.			JUN 10 1969			Nicholas Judge				



2123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

08604

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08598

1. DECEASED NAME (Type or print)		First CYRUS	Middle	Last JOHNSON	2a. DATE OF DEATH Month Day Year 6 15 69		2b. HOUR M
3. SEX M	4. RACE White		5. DATE OF BIRTH 7-3-86		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. - G.A.O.		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER 3605-Varnum St.	
14. FATHER'S NAME First Middle Last William Johnson		15. MOTHER'S MAIDEN NAME First Middle Last Mary Gooch		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or (unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO 578-52-3703		17. INFORMANT Address Mrs. Edna M. Haslett (Rd. S., Darien.					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 201.0 INFLUENZA - ASPIRATION Conn. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days DUE TO, OR AS A CONSEQUENCE OF (b) ATELECTASIS DUE TO, OR AS A CONSEQUENCE OF (c) BRONCHIAL TUMOR							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1967 , 19, to 6-15-1969 , that (I) (we) last saw the deceased alive on 6-15-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert L. Giamer MD		22c. DATE SIGNED 6-15-69		22d. PHYSICIAN'S NAME (Type) Home Inc.			
22e. ADDRESS 8484-16th St 887d.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/17/69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		24a. ADDRESS Mt. Rainier, Md.		25a. RECD BY REGISTRAR JUN 20 1969		25b. REGISTRAR'S SIGNATURE James J. Judge	

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1539

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08605		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08599	
Item 5 Film 444 7/14/69 kk		CERTIFICATE OF DEATH			
1 DECEASED NAME (Type or print) Floy Ernest Johnson			2a. DATE OF DEATH 6 Month 16 Day 69 Year		2b. HOUR 4:45 PM
3 SEX M	4. RACE Negro	5. DATE OF BIRTH 2/22/1894		6. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Texas	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home Building Entry		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.		13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. USUAL CITY, IN 1959 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 603 4th St NW
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO 466-28-2143		17. INFORMANT Lydia I. Johnson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Cancer 1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. (b) Cancer of the bowel DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2/22, 1969 to 6/16, 1969 , that (I) (we) last saw the deceased alive on 6/15, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE [Signature]				22c. DATE SIGNED 6/16/69	
22d. PHYSICIAN'S NAME (Type) [Signature]				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE 6-20-69		23c. NAME OF CEMETERY OR CREMATORY HOUSTON-TEXAS-	
23d. LOCATION (City or Town) (County) (State) HOUSTON-TEXAS		24. FUNERAL DIRECTOR Brown + Davidson F.H. INC.			
25a. REC'D BY REGISTRAR JUN 23 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Over Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

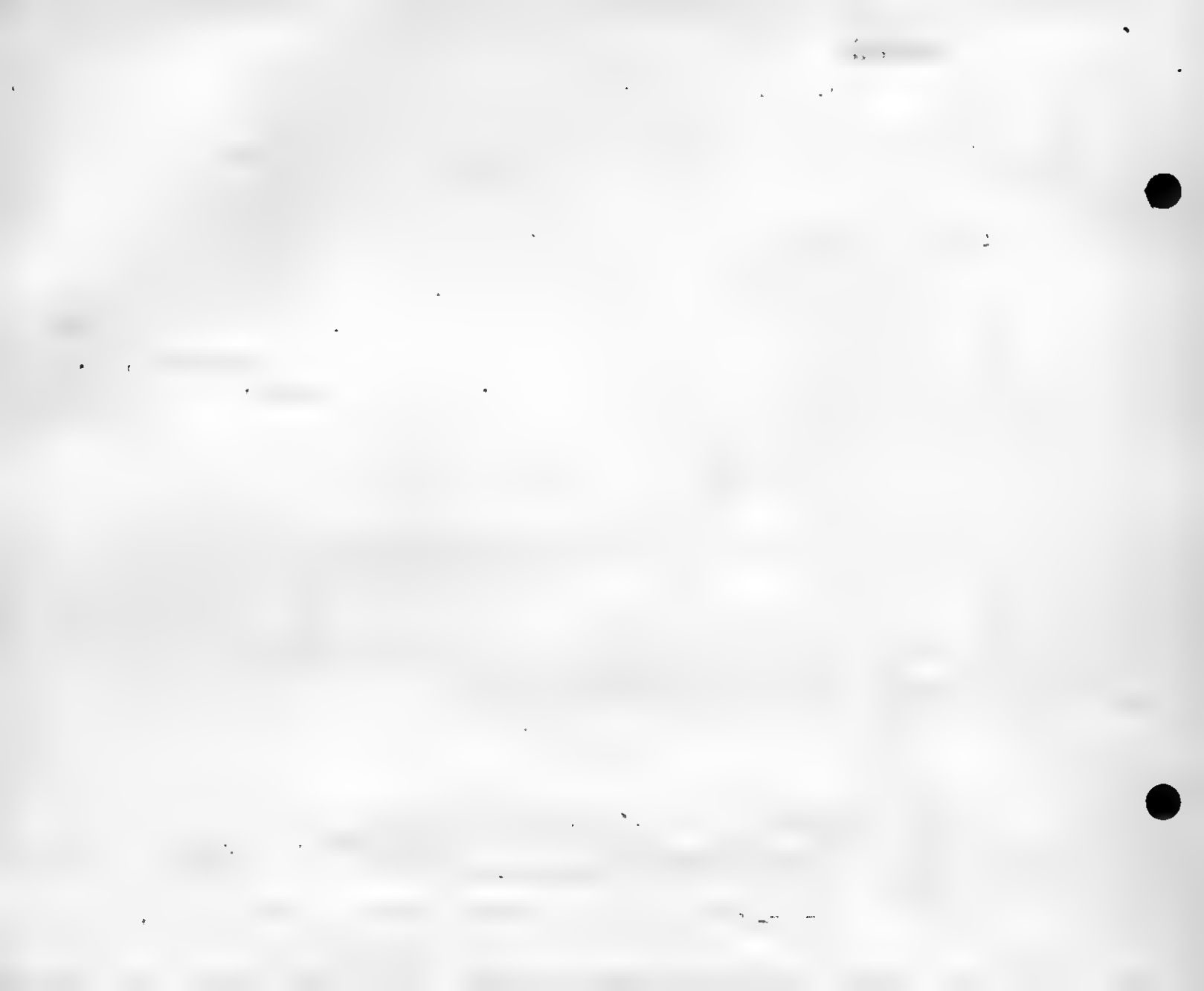
Items 18-21a Film 414 MARYLAND STATE DEPARTMENT OF HEALTH
7-3-61 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08606

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08600

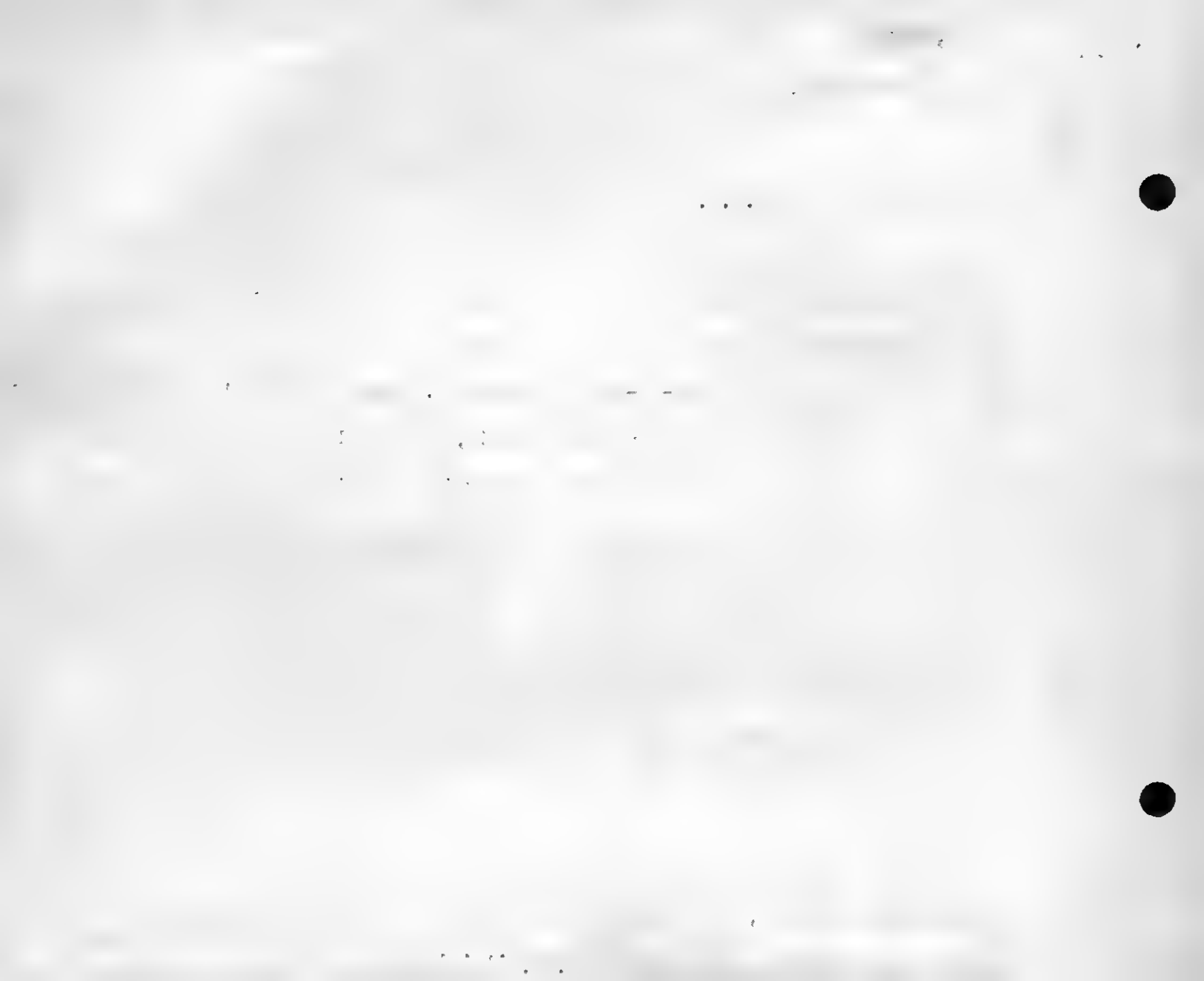
1. DECEASED-NAME (Type or Print) PATRICIA ANN JOHNSON			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6 19 1969			2b. HOUR 7:35 AM		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 4/9/52	6. AGE (In years last birthday) 17 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 6 Day 19 Year 1969		
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. COUNTY OF DEATH MONTGOMERY			10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) STUDENT			12b. KIND OF BUSINESS OR INDUSTRY			13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		
13b. COUNTY Mont.			13c. CITY OR TOWN Kensington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 4017 BYRD ROAD			14. FATHER'S NAME First CLIFFORD Middle F. Last JOHNSON			15. MOTHER'S MAIDEN NAME First RUTH Middle MILLER Last MILLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) NO			16b. SOCIAL SECURITY NO NONE			17. INFORMANT Kensington, Md. Cmdr. Norman Peckenpau, Friend, 4014 Byrd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral laceration due to auto accident DUE TO, OR AS A CONSEQUENCE OF (b) auto accident DUE TO, OR AS A CONSEQUENCE OF (c) auto accident								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day, Year 6-16 19 69 4:25 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased was passenger in car which veered across road struck tree.		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street			21f. LOCATION Street or R.F.D. No. City or Town County State Flyers Mill Rd. & Drum Ave. Kens. Mont. Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden Reap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED June 19, 1969		
EXAMINER'S NAME (Type) BELDEN REAP, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, City, Town or County) 11502 Grandview Ave., Wheaton, Md.			23a. BURIAL, CREMATION REMOVAL (Specify) Burial			23b. DATE 6-23-1969		
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery			23d. LOCATION (City or Town) (County) (State) Arlington County, Virginia			24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.		
ADDRESS 4190 WISC. AVE., N. W. WASH., D. C. 20016			25a. REC'D BY REGISTRAR JUN 23 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08607										
CERTIFICATE OF DEATH										
08601										
1. DECEASED NAME (Type or print) Frederick aka FRED					Middle W		Last JONES		2a. DATE OF DEATH Month June Day 21 Year 1969	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11/20/95		6. AGE (in years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Beltsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Leptonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rte #1, Box 152A		
14. FATHER'S NAME First William Spencer Jones Middle Last 					15. MOTHER'S MAIDEN NAME First Rosie Middle Last 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No		16b. SOCIAL SECURITY NO 214-30-5477		17. INFORMANT Harriet R. Jones		Address Route #1, Laytonsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 2041 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic lymphocytic leukemia DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State 					
22a. I certify that (I) (this hospital) attended the deceased from June 22, 1969 , to June 22, 1969 , that (I) (we) lost saw the deceased alive on June 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Sidney J. Chen, M.D.					DEGREE M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED June 22, 1969			
22d. PHYSICIAN'S NAME (Type) Sidney J. Chen, M.D.					22e. ADDRESS 5130 Wisconsin Ave., N.W., Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE June 24, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland				
24. FUNERAL DIRECTOR Joseph Gawler's Sons		ADDRESS 5130 Wisconsin Ave., N.W., Washington, D.C.		25a. REC'D BY REGISTRAR SUN 26 1969		25b. REGISTRAR'S SIGNATURE 				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08608

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08602

1 DECEASED-NAME (Type or Print) <i>Arthur T. Kann</i>		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month Day Year <i>June 19 1969</i>		2b. HOUR <i>5:00 AM</i>
3 SEX <i>Male</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>11-21-24</i>	6 AGE (in years at birthday) <i>44</i> YEARS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) <i>Wash DC</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>6709 Tildenwood La.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Plans Officer</i>
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>		13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Rockville</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last <i>Larry C. Kann</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Ethel Hope</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Yes</i> (If yes, give year or dates of service) <i>1944-1945</i>		16b SOCIAL SECURITY NO <i>579-20-5979</i>	17 INFORMANT <i>Wife Elsie Kann</i> ADDRESS <i>home above</i>	
18. CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Insufficiency - Acute -</i> <i>1123</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Arteriosclerosis - Severe -</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John G. Ball</i> EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>		22b DATE SIGNED <i>June 19, 1969</i>
23a BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE <i>6-23-69</i>	23c NAME OF CEMETERY OR CREMATORY <i>Gulpepper Natl Cem.</i>	23d LOCATION (City or Town) (County) (State) <i>Culpepper, Virginia</i>	
24 FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a REC'D BY REGISTRAR <i>JUN 24 1969</i>	25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

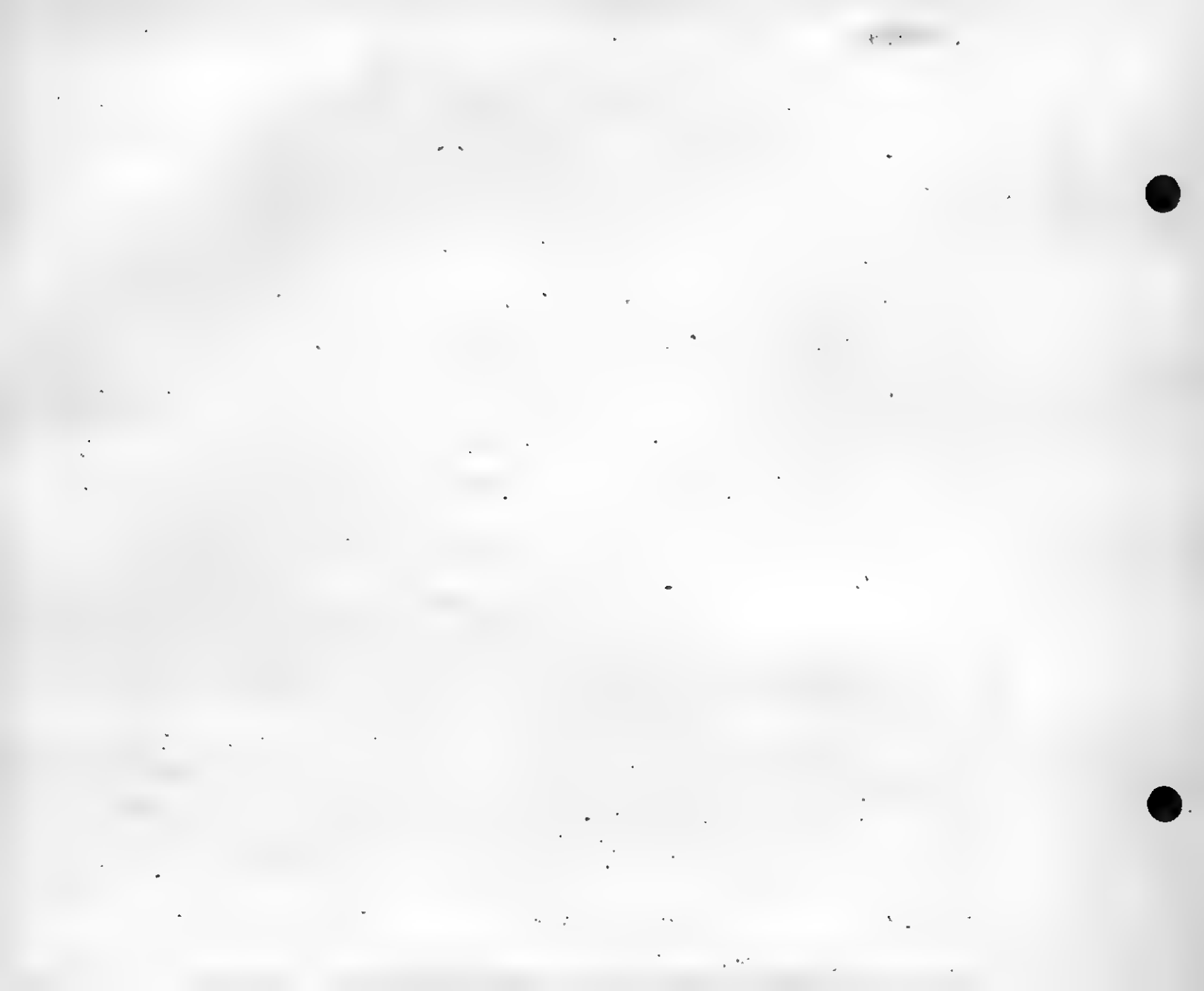
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08609

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08603

1 DECEASED NAME (Type or print) DAVID		First Middle Last		2a DATE OF DEATH Month 6 Day 30 Year 69		2b HOUR 1:30 A.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 2/22/85		6 AGE (In years lost birthday) 84 YRS.	
7a BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY Md	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Printer		12b KIND OF BUSINESS OR INDUSTRY PRINTING.	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Mont.		13c CITY OR TOWN Silver Spring		13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 8105 Eastern Avenue.		14 FATHER'S NAME First CHARLES Middle KAYE Last UNKOWN		15. MOTHER'S MAIDEN NAME First UNKOWN Middle UNKOWN Last UNKOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 052-09-6373		17. INFORMANT HELEN P KAYE - 8105 EASTERN AVENUE		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conjunctive Heart Failure 4123 DUE TO, OR AS A CONSEQUENCE OF (b) HEAT EXHAUSTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Coronary Sclerosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours 48 hours 3 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10 , 19 65 , to 6/30 , 19 67 , that (I) (we) lost saw the deceased alive on 6/29 , 19 67 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M.W. Shapiro		22c. DATE SIGNED 6/30/69		22d. PHYSICIAN'S NAME (Type) M.W. SHAPIRO, M.D.		22e. ADDRESS 8105 EASTERN AVE, SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-1-1969		23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK FALLS CHURCH		23d. LOCATION (City or Town) (County) (State) VA.	
24. FUNERAL DIRECTOR GOLDEN FLOWER HOME 4217 9th St. NW		ADDRESS		25a. REC'D BY REGISTRAR JUL 3 1969		25b. REGISTRAR'S SIGNATURE [Signature]	



2509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
ELLA			M		KELLY	6 Month 4 Day 69 Year		2:05 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		Negro		8-12-03		65 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.A				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			HOLY CROSS			Domestic			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before address on) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MONTGOMERY			Montgomery			Spencerville		13e. STREET AND NUMBER	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			
First Middle Last			First Middle Last			Address			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
						Henderson			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebrovascular Accident									
DUE TO, OR AS A CONSEQUENCE OF									
Cerebral Arteriosclerosis									
DUE TO, OR AS A CONSEQUENCE OF									
Diabetes Mellitus									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11, 1968, to 6/9, 1969, that (I) (we) lost saw the deceased alive on 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
M.D. R.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		6/4/69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			6/8/69		Roundoak Cemetery		Spencerville, Md		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mike Snowden						DATE JUN 10 1969		Charles Judge	
Rockville Md.									

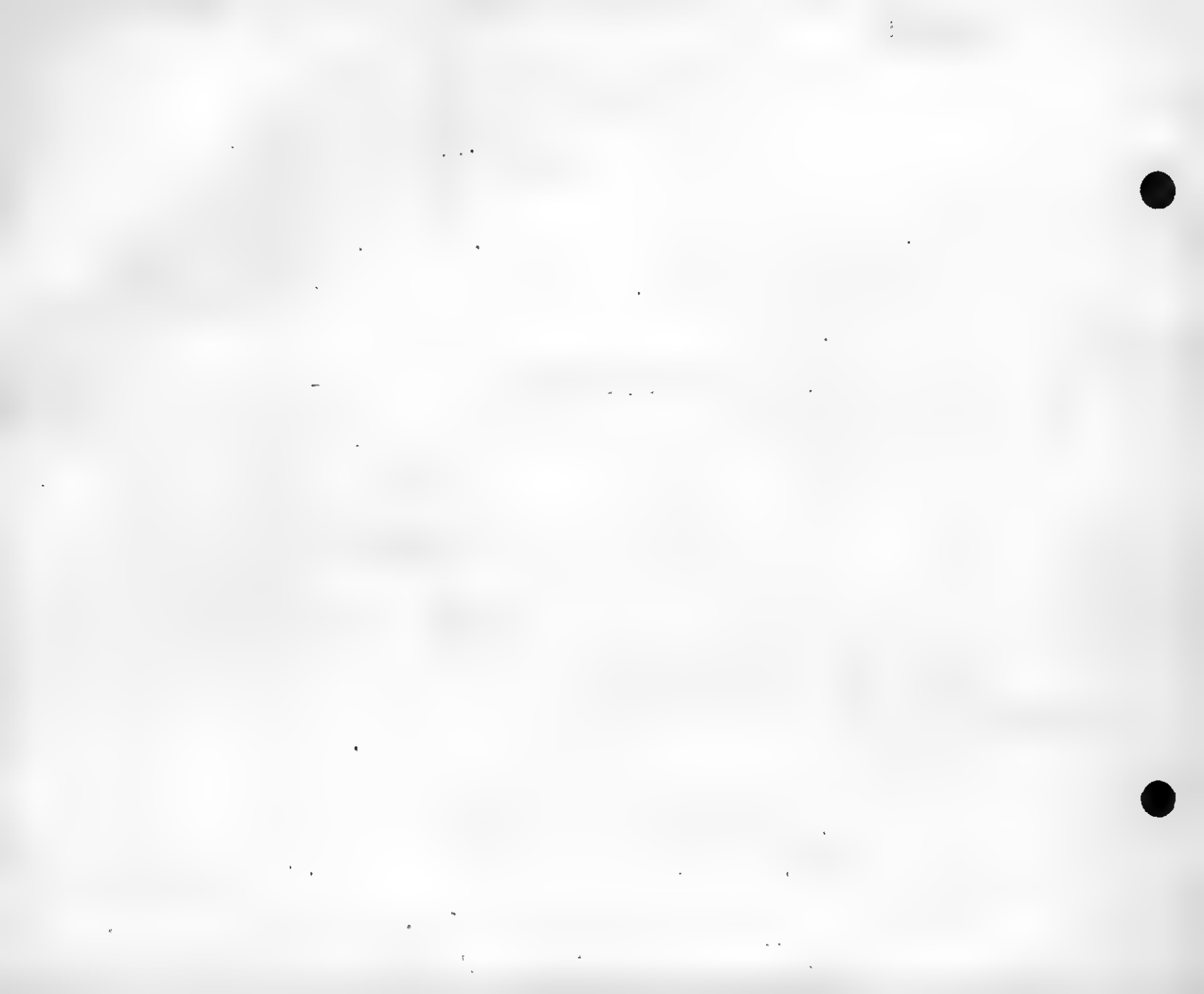
4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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 VR A15
45M

<div>08611</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>08605</div>										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
MARGARET			LILLIAN KEZER			June 3 1969		12:52A M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER YEAR IF UNDER 24 HRS		
female		white		August 23, 1900		68 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
New Hampshire		U.S.A.				Montgomery Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park			Washington San. & Hospital			housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY, LIMITS?		13e. STREET AND NUMBER			
Maryland			Chillum		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1410 Legation Road			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
John Harrigan			Margaret Finn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
No			578-54-9525B		Mr. Roland Kezer - husband					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Unrecorded information</u>									15 minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>A. S.H.D. - congestive heart failure</u>									2 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Pneumonia</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR AM Month Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
			P M 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>6/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/28</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (die) (did not) view the body after death.										
22b. SIGNATURE						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
Hugh W. Ireys, M.D.						7105 Riggs Rd. Lewisdale, Md.				
23a. BURIAL, CREMATION (Type)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial (Type)			6/6/69		Gate of Heaven Cem.		Silver Spring, Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Nalley's Funeral Home Inc.						DATE JUN 9 1969		J. Charles Judge		



7432

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
BABY BOY			King			6 Month 19 Day 69 Year		2:15 AM	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS	
Male		White		6-14-69		YRS		7 21	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Md		USA				Montgomery		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Wash. San. & Hosp.							
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Montgomery		Takoma Park				8716 Gilbert Place	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
William Francis King			Mary Margaret Anaheim						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
				Hospital chart					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Prematurity								7 hrs	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) Poss. Porencephaly								7 hrs.	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE					22c. DATE SIGNED				
Herbert M. Solomon MD DEGREE					ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		15 June 69		
22d. PHYSICIAN'S NAME (Type) Herbert M. Solomon M.D.					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		6-15-69		Washington San & Hospital Takoma Park, Mont., Maryland					
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J.D. Ruffcorn, Takoma Park, Maryland					JUN 17 1969		Charles Judge		

1589

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08613

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08607

1 DECEASED NAME (Type or print) Edward C. Knight			2a DATE OF DEATH Month June Day 5 Year 1969			2b HOUR 12:45 M	
3 SEX MALE		4 RACE white		5 DATE OF BIRTH JAN 17, 1910		6 AGE (In years last birthday) 59 YRS.	
7a BIRTHPLACE (State or foreign country) Canada		7b CITIZEN OF WHAT COUNTRY? USA Canada		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, OR INSTITUTION (if not in hospital give street address) Suburban		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Superintendent		12b KIND OF BUSINESS OR INDUSTRY Superintendent	
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY (in 1969) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 620 Aster Road		14 FATHER'S NAME First Harold B. Middle Knight Last Knight		15 MOTHER'S MAIDEN NAME First Laura Middle Lambert Last Lambert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO 578-50-7497		17 INFORMANT Wife Ruth Knight, Home address		Address Home address	
18. CAUSE OF DEATH (Enter only one cause per PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Peritonitis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b) RETROPERITONEAL CARCINOMA							
DUE TO, OR AS A CONSEQUENCE OF (c) UNDIFFERENTIATED							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from MAY 14 , 19 69 , to JUNE 5 , 19 69 , that (I) (we) last saw the deceased alive on JUNE 4 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.							
22b. SIGNATURE Edward S. Witowski, MD				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED JUNE 5, 1969	
22d. PHYSICIAN'S NAME (Type) EDWARD S. WITOWSKI, JPM				22e. ADDRESS 8218 WISCONSIN AVENUE BETHESDA MARYLAND 20814			
23a BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b DATE 6-7-69		23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Parklawn, Montg. Co. Md.	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.				FILED BY REGISTRAR JUN 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08614

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08608

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH		Month	Day	Year	2b. HOUR
Lulu Wilklow Koester					6-1-		1969	9:10		A
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years)	7 UNDER YEAR	8 UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR
F	W	7-14-80 79		89	MONTHS	DAYS	HOURS	MIN.	Month 8 Day 1 Year 1969	9:10 A
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Virginia		US				Montgomery		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park		Washington San & Hosp		housewife		own home				
13a. USUAL RESIDENCE (Where deceased lived, if not institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.		Montgomery		Silver Spring				759 Silver Spring Ave		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
John H Wilklow					Susan M J. Wilklow					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS				
8		0-9-54-9830-2		Mr. George Wilklow		759 Silver Spring Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>										Hours
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio-Vascular Disease</u>										Years
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED		
John S. Ball		M.D.						June 4, 1969		
ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		June 4, 1969		Columbia Gardens Cemetery		Washington, Virginia				
24. FUNERAL DIRECTOR		25a. REC'D BY REG-STRAR		25b. REGISTRAR		25c. DATE				
James E. Penhrey, Sr.		JUN 5 1969		JUN 5 1969						

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08615 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08609					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED-NAME (Type or Print)			First JOSEPH		Middle JOHN		Last MARTINO		2a DATE KNOWN OF DEATH Month <u>5</u> Day <u>20</u> Year <u>1969</u>		2b HOUR <u>2:30</u> M				
3 SEX Male		4 RACE White		5 DATE OF BIRTH 3-31-18		6 AGE (in years last birthday) 51 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month <u>6</u> Day <u>20</u> Year <u>1969</u>		2d HOUR <u>6:30</u> M	
7a BIRTHPLACE (State or foreign country) PENNA.			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery Md						
10 CITY OR TOWN OF DEATH Silver Spring				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Thomas Drive				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman				12b KIND OF BUSINESS OR INDUSTRY			
13a U.S.A. RESIDENCE (Where deceased lived if institution residence before admission) STATE Md				13b COUNTY Montgomery				13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 11 Thomas Drive			
14 FATHER'S NAME First Paul			Middle Kriso			Last Katherine			15 MOTHER'S MAIDEN NAME First (unk)						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOCIAL SECURITY NO (If yes give war or dates of service) WW II yes				17. INFORMANT Joyce Kriso-11 Thomas Drive-Silver Spring, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>412</u> <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, P.O. box, or county) June 20, 1969				22b. DATE SIGNED							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE June 24, 1969				23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery				23d. LOCATION (City or Town) (County) (State) Dallas Bor., Luzerne, Pa.			
24 FUNERAL DIRECTOR Thomas L. Goeck Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Avenue Silver Spring, Md.				25a. REC'D BY REGISTRAR JUN 25 1969				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3949

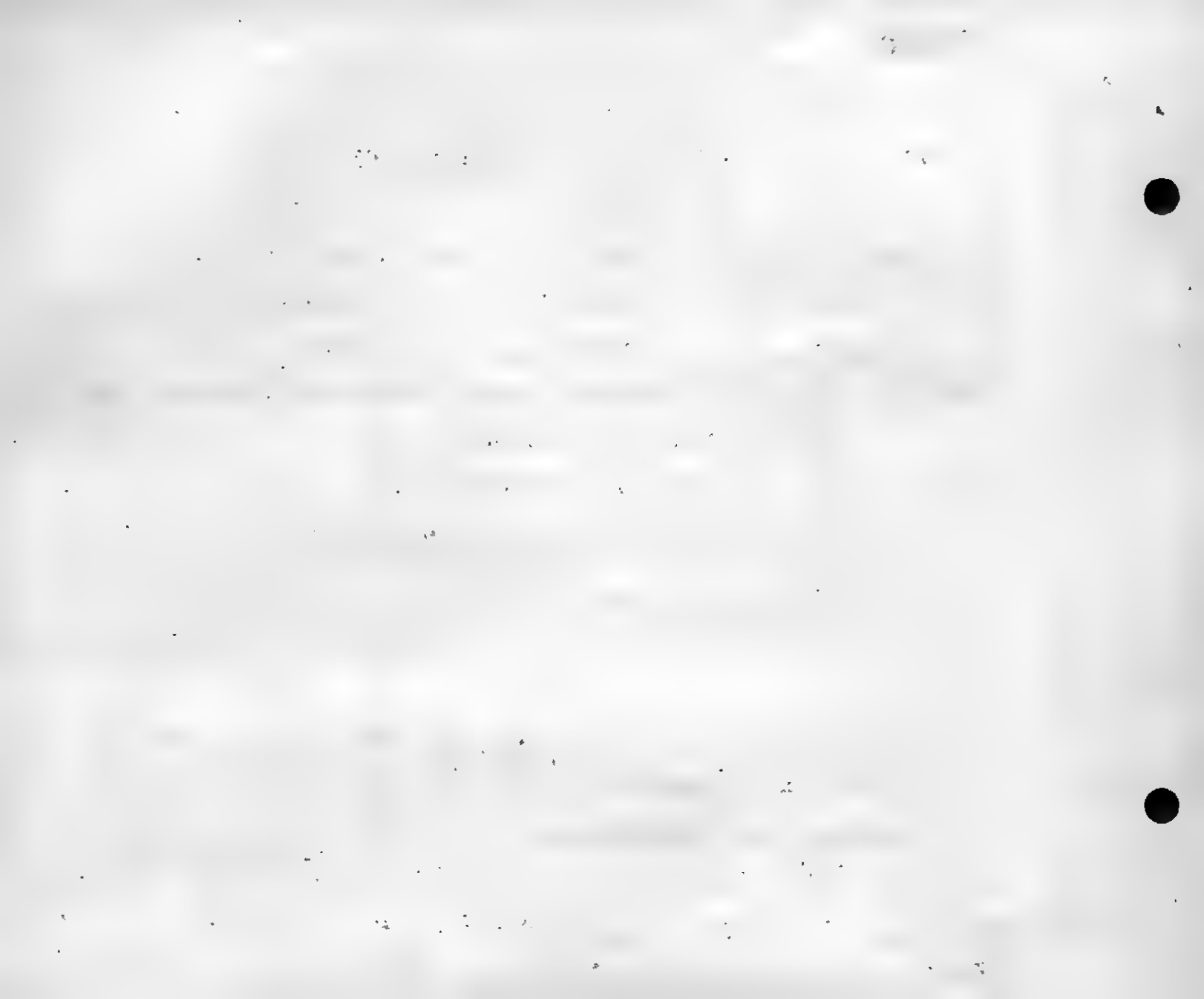
08616

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08610

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR A M	
Ernest			Joseph	Kurdela	June 13, 1969			2:10 A	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		20 April 1913		56 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
New Jersey		USA				Montgomery Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		The Clinical Center, NIH		Construction worker					
13a SOCIAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
New Jersey				Hackettstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 262, Mine Hill Road	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
Stephen				Kurdela	Tillie				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT					
Yes		1942-1945		Bethesda, Md. 20014 The Medical Records, The Clinical Center					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u>								Days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) <u>Post-operative cardiac failure</u>								3 Weeks	
(c) <u>Post-operative hepatorenal failure</u>								3 Weeks	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Mediastinitis</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
28 May 1969		Mitral valve replacement			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that he (this hospital) attended the deceased from April 14, 1969, to June 15, 1969, that he (we) last saw the deceased alive on June 15, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did not) view the body after death.									
22b SIGNATURE				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED	
Bradley M. Rodgers								16 June 1969	
22d PHYSICIAN'S NAME (Type)				22e ADDRESS					
Bradley M. Rodgers, M. D.				The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
REMOVAL		6-18-69		Holy Cross Cemetery		N. Arlington		N.S.	
24 FUNERAL DIRECTOR				ADDRESS		25a RECEIVED BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Robert A. Humphreys				4557 Wisconsin Ave. N.W. Wash. D.C.		JUN 18 1969		Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000. Page 5 may be retained for your files.

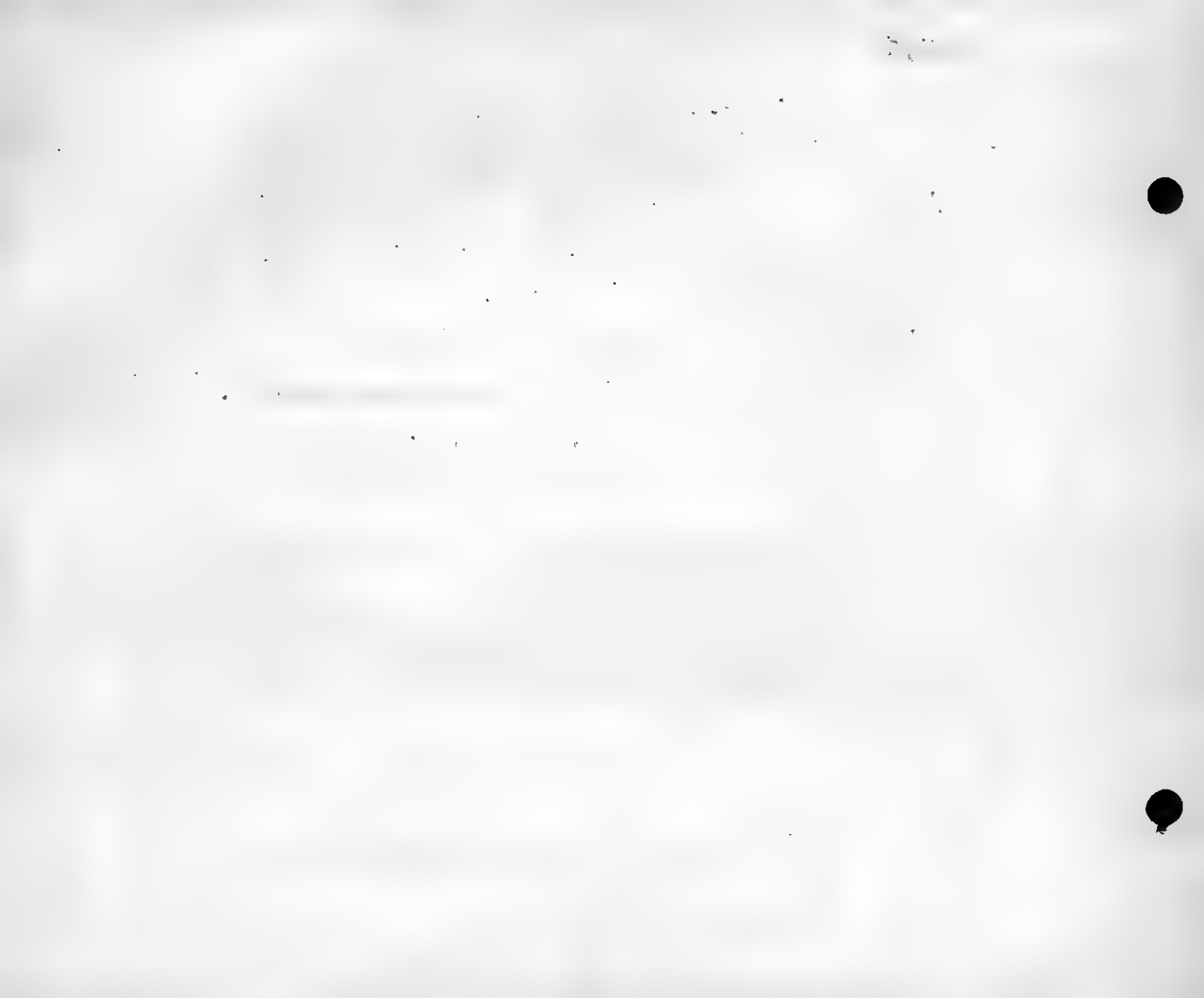
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08617

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08611

1 DECEASED-NAME (Type or Print) <u>Thomas Conway Kyle</u>			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>6</u> Day <u>5</u> Year <u>1969</u>			2b HOUR <u>7:15 PM</u>
3. SEX <u>male</u>	4 RACE <u>white</u>	5 DATE OF BIRTH <u>Dec. 27 1896</u> YRS	6 AGE (In years last birthday) MONTHS <u>72</u> DAYS <u>12</u> HOURS <u>12</u> MIN	7c DATE PRONOUNCED DEAD Month <u>June</u> Day <u>5</u> Year <u>1969</u>	2d HOUR <u>7:15 PM</u>	
7a BIRTHPLACE (State or foreign country) <u>Ill.</u>	7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <u>Montgomery</u> Md.			
10. CITY OR TOWN OF DEATH <u>Bethesda</u>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban</u>		12a U.S.A. OCCUPATION (Kind of work done during most of work week, even if retired)	12b KIND OF BUSINESS OR INDUSTRY <u>MANUFACTURER REP SELF EMPLOYED</u>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>	13b COUNTY <u>Mont.</u>	13c CITY OR TOWN <u>Rockville</u>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <u>627 Beale Drive</u>		
14. FATHER'S NAME First <u>JAMES</u> Middle <u>KYLE</u> Last <u>JOANNA</u>	15. MOTHER'S MAIDEN NAME First <u>JOANNA</u> Middle <u>CONWAY</u> Last <u>CONWAY</u>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give year or dates of service) <u>I</u>			
16b SOCIAL SEC. NO. <u>321-07-5842</u>			17. INFORMANT <u>JANE MEAD (DAUGHTER)</u> ADDRESS <u>GLEN ELYN, ILL.</u>			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aneurysm, ruptured, abdominal aorta</u>						<u>4 hr.</u>
DUE TO OR AS A CONSEQUENCE OF (b) <u>Cardio-Vascular Disease.</u>						<u>years.</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>last</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <u>John B. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <u>JUNE 6, 1969</u>		
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE <u>JUNE 9, 1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM</u>	23d LOCATION (City or Town) <u>WHEATON</u> (County) <u>Md.</u> (State)	25a. REC'D BY REGISTRAR <u>JUN 11 1969</u>		
24. FUNERAL DIRECTOR <u>John F. D'Elia</u>	25b. REGISTRAR'S SIGNATURE <u>John F. D'Elia</u>		25c. REGISTRAR'S SIGNATURE <u>John F. D'Elia</u>			



08618

CERTIFICATE OF DEATH

08612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) JAMES ALBERT LAFONTAINE		2a. DATE OF DEATH Month 6 Day 23 Year 69		2b. HOUR 7:48 A.M.
3 SEX MALE	4. RACE A.M.E.R.-WHITE	5. DATE OF BIRTH 4-19-07	6. AGE (n years last birthday) 62 YRS	IF UNDER 1 YEAR MONTHS 2 DAYS 5
7a. BIRTHPLACE (State or foreign country) D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.MERICA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL OR INST.TUTION (If not in hospital give street address) WASH. SANITARY HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) OWNER-	12b. KIND OF BUSINESS OR INDUSTRY CAR-WASH	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE M.D.	13b. COUNTY MONTG.	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9612 LOBAINE AVE.
14. FATHER'S NAME First Middle Last CHARLES LAFONTAINE	15. MOTHER'S MAIDEN NAME First Middle Last MABEL ENDERMAUER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 577-14-9320	17. INFORMANT PTS. CHART Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic epidermoid carcinoma 1451 DUE TO, OR AS A CONSEQUENCE OF (b) Epidermoid carcinoma soft palate DUE TO, OR AS A CONSEQUENCE OF (c) 11 mto.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mto.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 8-27, 1968 to 6-23, 1969 , that (I) (we) saw the deceased alive on 6-22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Harry N. Carlton, MD		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6-23-69
22d. PHYSICIAN'S NAME (Type) HARRY N. CARLTON		22e. ADDRESS 8811 Colonsville Rd., S.S. Md.		
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE 6-26-69	23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cem.	23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR Francis J. Collins		ADDRESS 500 University Bldg. W. Sil. Sp. Md.		25a. REC'D BY REGISTRAR JUN 27 1969
				25b. REGISTRAR'S SIGNATURE John J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08619						08613					
1. DECEASED NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
BERNADETTE K. LAMERS						JUNE 21 1969			7A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		CAUCASIAN		1-12-86		83 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
WASH. D.C.		USA				MONTGOMERY Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
BURTONSVILLE				3408 GREEN CASTLE RD.				SET. SALESMAN		CLOTHING	
13a. USUAL RESIDENCE (Where deceased lived if institution - Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.				MONTG.		BURTONSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3408 GREEN CASTLE RD.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
CLEMENT - KROGMANN				MARY M. LOCHBOEHLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address					
NO						ANNA L. RUPPERT, 5120 CONN. AVE, WASH., D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION											
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ATHEROSCLEROSIS											
DUE TO, OR AS A CONSEQUENCE OF (c) INTEROSCULATIC HEART DISEASE											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Immediate											
20 years											
10 years											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-11, 1968, to 6-21, 1969, that (I) (we) last saw the deceased alive on 5-30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d.d) (d did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Burton A. Johnson										6-21-69	
22b. PHYSICIAN'S NAME (Type)						22c. ADDRESS					
Burton A. Johnson						4140 Sandy Springs Rd, Burtonsville, Md.					
23a. BURIAL, CREMATION, REMOVAL, SPECIFY				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial				6/24/69		St. MARY'S CEMETERY		WASHINGTON, D.C.			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JOS. GAWLER'S SONS						WASH., DC		JUN 26 1969		Charles Jones	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in (circled) Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH		2b. HOUR	
Herbert Webster Layton						Month 5 Day 4 Year 1969		12:00 AM	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2c. DATE PRONOUNCED DEAD	2d. HOUR
M.	W.	May 22 1914	55 YRS					Month June Day 4 Year 1969	12:03 AM
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH			
Maryland	USA	WIDOWED		DIVORCED		Montgomery			
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work night, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Bethesda	5815 Battery Lane		Inspector		Building				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER					
Md.	Montgomery	Bethesda	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5015 Battery Lane Apt 207					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
William O.			Layton	Clara				Justice	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
No		218-18-1751		Mrs Margaret Will Layton		Bethesda, Md. 5015 Battery Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.								Sudden.	
4124 DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease -									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
CAUSE OF DEATH		HOUR A.M. P.M. 19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John G. Ball		CHIEF MED. CAL. EXAMINER <input type="checkbox"/>		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)		John G. Ball, M.D.		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		June 4, 1969 Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		County	State
Burial		June 6, 1969		Lake View		Nr. Eldersburg, Md.			
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REG. STRAR		25b REGISTRAR'S SIGNATURE	
Olin L. Molesworth, Damascus, Md.						JUN 9 1969		Richard Justice	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 414 Maryland Department of Health
7-1-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08621

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

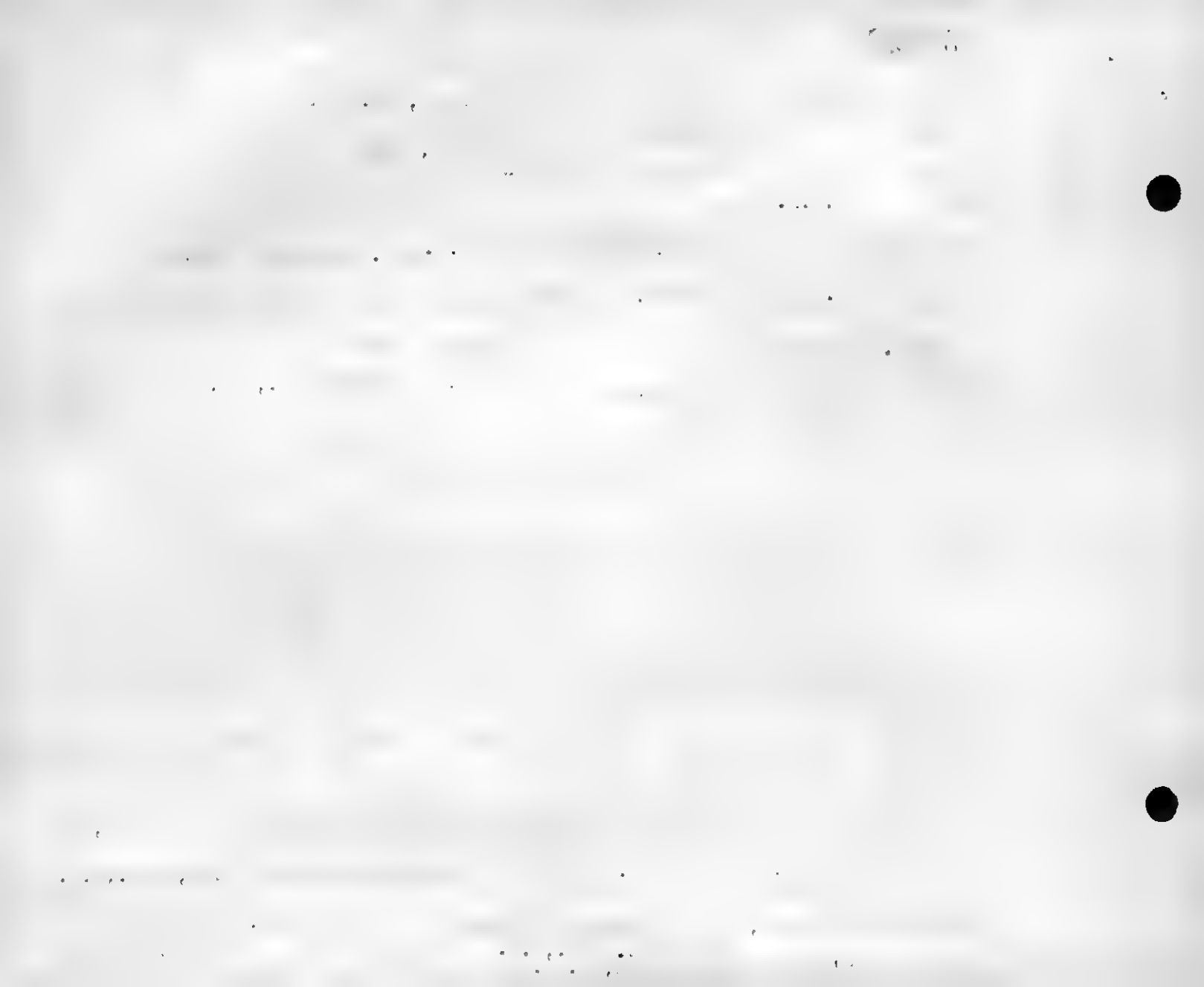
08615

1. DECEASED NAME (Type or Print) Halla		First O'Dell		Middle Leach		Last		2a. DATE KNOWN OF DEATH Month 6 Day 8 Year 1969		2b. HOUR 3:35 AM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 11-18-85	6 AGE (in years) 83 YRS	7 MONTHS	8 DAYS	IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 6 Day 8 Year 1969		2d. HOUR 3:35 AM	
7a. BIRTHPLACE (State or foreign country) W Va		7b. CITIZEN OF WHAT COUNTRY? U.S. Amer		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash San & Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) - STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY, M-F? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 11235 Oak Leaf Dr #1908			
14. FATHER'S NAME Eli Metcalf				First Middle Last		15. MOTHER'S MAIDEN NAME Mahalia Robinson				First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 271-14-35980		17. INFORMANT (Son)				ADDRESS Sil Spring Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to 911X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) aspiration of gastric contents DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 8:30 AM 6-8-1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased vomited and aspirated gastric contents							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hospital		21f. LOCATION Street or R.F. No Wash. San. & Hosp. Takoma Park		City or Town Montg.		County Md.		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED June 8/1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 14, 1969		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City or town) Colton		(County) Jackson		(State) Ohio	
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc., Silver Spring, Md.				25a. REC'D BY REGISTRAR JUN 16 1969		25b. REGISTRAR'S SIGNATURE John Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
JAMES			H			LE FEAVER, Sr.		JUNE 30 1969 4:30 M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (n years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		May 11, 1885		84 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Ohio		U.S.A.				MONTGOMERY Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
KENSINGTON			KENSINGTON GARDENS N.H.			Ref. consulting engineer				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
MD.			MONTG.		CHEVY CHASE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4602 ROSEMARY STREET	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
John B. Le Feaver			Lucelia Foster							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT					
No			Unknown		JAMES H. LE FEAVER, JR., SON, SAME AS #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CALLED BY:										
IMMEDIATE CAUSE (a) Myocardial Infarct										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Arteriosclerosis										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Right hemiparesis (1968)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. B.TING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from April 1, 1969, to 6/30, 1969, that (I) (we) saw the deceased alive on 6/23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE			22c. DATE SIGNED							
John W. Latimer, Jr. MD.			JUNE 30, 1969							
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
JOHN W. LATIMER, JR.			1728 MASSACHUSETTS AVE., NW, WASH., D.C.							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Cremation		July 1, 1969		Cedar Hill Crematory		Suitland, Maryland				
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG STRAR		25b REG STRAR'S SIGNATURE				
Joseph Gawler's Sons		5130 Wisconsin Ave., N.W. Washington, D.C.		JUL 7 1969		John W. Judge				



08623

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08617

1 DECEASED NAME (Type or print) First Middle Last MARGARET Cecilia LEONARD		2a. DATE OF DEATH 6 Month 28 Day 69 Year		2b. HOUR 4:52 PM
3 SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH 11-25-83		6 AGE (In years last birthday) 85 YRS
7a BIRTHPLACE (State or foreign country) DC	7b CITIZEN OF WHAT COUNTRY? AMER.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED - DEPT OF ARMY		12b KIND OF BUSINESS OR INDUSTRY Administrative
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c CITY OR TOWN BETHESDA	13d INS OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 5218 NAHANT ST
14. FATHER'S NAME First Middle Last Joseph LEONARD	15. MOTHER'S MAIDEN NAME First Middle Last MARGARET Reidy		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)	
16b SOCIAL SECURITY NO 578-32-0774-T		17 INFORMANT MRS. Michael Schommer S.S. Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (d) hypertension				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 11-24-69 , 19 69 , to 12-2-69 , 19 69 , that (I) (we) last saw the deceased alive on 12-2-69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE SERUCH T. KIMLE		22c DATE SIGNED 12-5-69		22d. PHYSICIAN'S NAME (Type) SERUCH T. KIMLE
22e ADDRESS 500 Univ. Blvd. W. Silver Spring, Maryland		22f REGISTERED JUL 2 1969		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 7-2-69	23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d LOCATION (City or Town) (County) (State) Washington D. C.	23e FUNERAL DIRECTOR Francis J. Collins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08624										
CERTIFICATE OF DEATH										
08618										
1. DECEASED-NAME (Type or print) <u>Virginia D Leser</u>					2a. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1969</u>					2b. HOUR <u>2:05 A.M.</u>
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>10-18-1894</u>			6. AGE (In years last birthday) <u>74</u> YRS.		7. UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>Penn.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u>				
10. CITY OR TOWN OF DEATH <u>Wheaton, Md.</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>			12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) <u>Secretary</u>			12b. KIND OF BUSINESS OR INDUSTRY <u> </u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE <u>Md.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. USJA. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER - <u>318 Code 20806</u> <u>3451 Chiswick Court</u>		
14. FATHER'S NAME First <u>PAUL</u> Middle <u>Ferris</u> Last <u>Devees</u>					15. MOTHER'S MAIDEN NAME First <u>Carnie</u> Middle <u>Ferris</u> Last <u> </u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>165-10-4031-D</u>		17. INFORMANT <u>John F. Leser Son 318 Manheim St Phila.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Central Arterial disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Peritonitis mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21c. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>		21d. DATE SIGNED <u>6/23/69</u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/13, 1967</u> , to <u>6/23, 1967</u> , that (I) (we) last saw the deceased alive on <u>6/22, 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Allan B. Cohan</u>					22c. DATE SIGNED <u>6/23/69</u>		22d. PHYSICIAN'S NAME (Type) <u>Allan B. Cohan, M.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>6/24/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>			23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300 4th St. N.E.</u>					25a. REC'D BY REGISTRAR <u>JUN 26 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Jordan</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

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08625

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 13 Film 6/16/69 kk

CERTIFICATE OF DEATH

08619

1 DECEASED NAME (Type or print) <u>Goldie</u>		First Middle Last		2a. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1969</u>		2b. HOUR <u>10:37</u> P.M.	
3. SEX <u>Female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>May 10, 1889</u>		6. AGE (In years last birthday) <u>80</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>Poland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <u>D.C.</u>		13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Bethesda</u>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME <u>Phillip</u>		First Middle Last		15. MOTHER'S M.A.DEN NAME <u>Lrene</u>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO <u>577-48-1044</u>		17. INFORMANT <u>Samuel L. Levy</u>		Address <u>1244 - Chic. Rd. S.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Myocardial infarction</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>Arteriosclerotic heart disease</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<u>Pulmonary edema, Diabetes mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1969</u> , to <u>June 5, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Sidney J. Cohen</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>June 5, 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>Sidney J. Cohen, M.D.</u>				22e. ADDRESS <u>50 W. Edmonston Drive, Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6/8/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FLESHVETERAD CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>	
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u>				25a. REC'D BY REGISTRAR <u>DATE JUN 11 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

968X
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office (page with form PM-3) Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

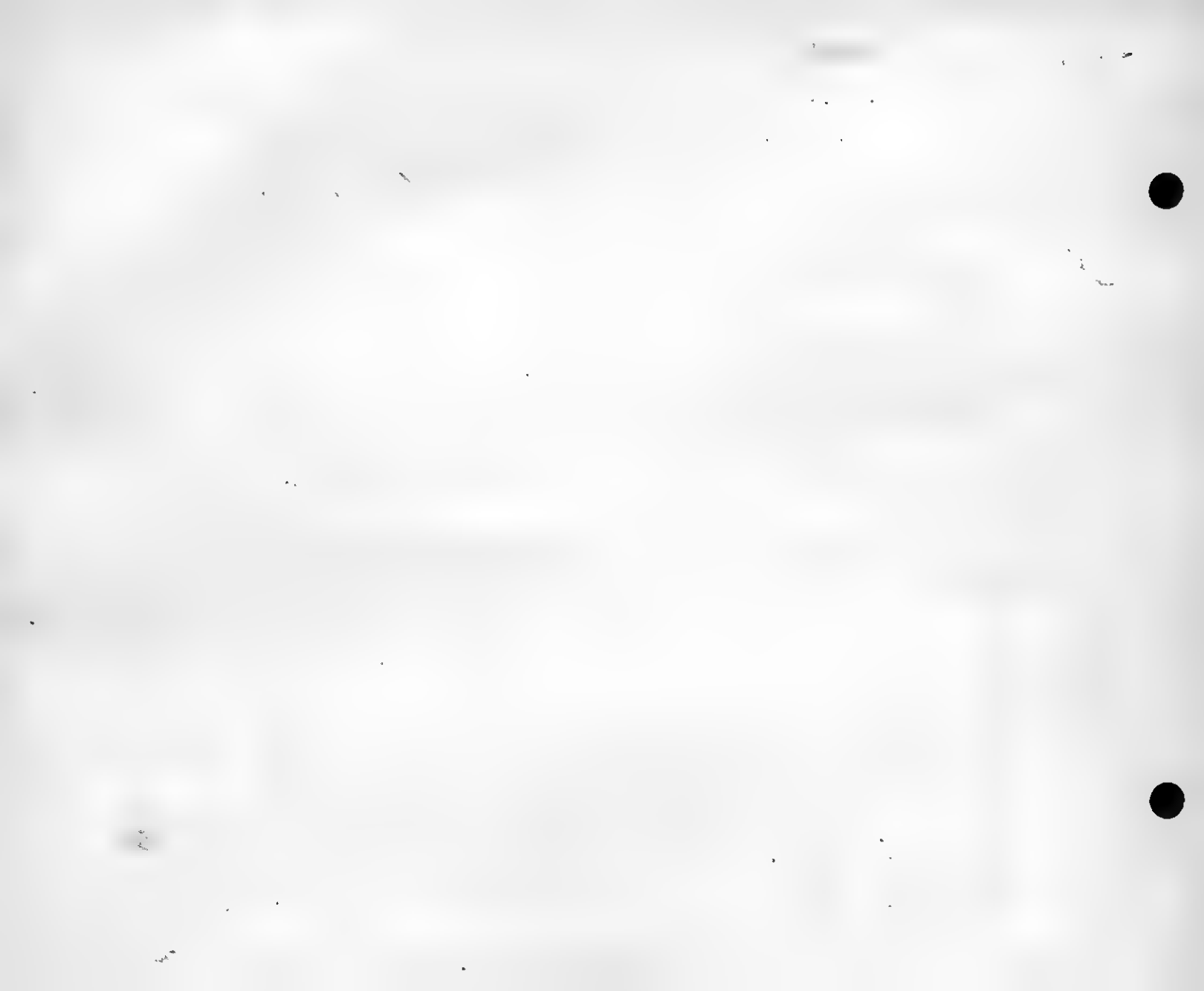
Items 15e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z, aa, ab, ac, ad, ae, af, ag, ah, ai, aj, ak, al, am, an, ao, ap, aq, ar, as, at, au, av, aw, ax, ay, az, ba, bb, bc, bd, be, bf, bg, bh, bi, bj, bk, bl, bm, bn, bo, bp, bq, br, bs, bt, bu, bv, bw, bx, by, bz, ca, cb, cc, cd, ce, cf, cg, ch, ci, cj, ck, cl, cm, cn, co, cp, cq, cr, cs, ct, cu, cv, cw, cx, cy, cz, da, db, dc, dd, de, df, dg, dh, di, dj, dk, dl, dm, dn, do, dp, dq, dr, ds, dt, du, dv, dw, dx, dy, dz, ea, eb, ec, ed, ee, ef, eg, eh, ei, ej, ek, el, em, en, eo, ep, eq, er, es, et, eu, ev, ew, ex, ey, ez, fa, fb, fc, fd, fe, ff, fg, fh, fi, fj, fk, fl, fm, fn, fo, fp, fq, fr, fs, ft, fu, fv, fw, fx, fy, fz, ga, gb, gc, gd, ge, gf, gg, gh, gi, gj, gk, gl, gm, gn, go, gp, gq, gr, gs, gt, gu, gv, gw, gx, gy, gz, ha, hb, hc, hd, he, hf, hg, hh, hi, hj, hk, hl, hm, hn, ho, hp, hq, hr, hs, ht, hu, hv, hw, hx, hy, hz, ia, ib, ic, id, ie, if, ig, ih, ii, ij, ik, il, im, in, io, ip, iq, ir, is, it, iu, iv, iw, ix, iy, iz, ja, jb, jc, jd, je, jf, jg, jh, ji, jj, jk, jl, jm, jn, jo, jp, jq, jr, js, jt, ju, jv, jw, jx, jy, jz, ka, kb, kc, kd, ke, kf, kg, kh, ki, kj, kk, kl, km, kn, ko, kp, kq, kr, ks, kt, ku, kv, kw, kx, ky, kz, la, lb, lc, ld, le, lf, lg, lh, li, lj, lk, ll, lm, ln, lo, lp, lq, lr, ls, lt, lu, lv, lw, lx, ly, lz, ma, mb, mc, md, me, mf, mg, mh, mi, mj, mk, ml, mm, mn, mo, mp, mq, mr, ms, mt, mu, mv, mw, mx, my, mz, na, nb, nc, nd, ne, nf, ng, nh, ni, nj, nk, nl, nm, nn, no, np, nq, nr, ns, nt, nu, nv, nw, nx, ny, nz, oa, ob, oc, od, oe, of, og, oh, oi, oj, ok, ol, om, on, oo, op, oq, or, os, ot, ou, ov, ow, ox, oy, oz, pa, pb, pc, pd, pe, pf, pg, ph, pi, pj, pk, pl, pm, pn, po, pp, pq, pr, ps, pt, pu, pv, pw, px, py, pz, qa, qb, qc, qd, qe, qf, qg, qh, qi, qj, qk, ql, qm, qn, qo, qp, qq, qr, qs, qt, qu, qv, qw, qx, qy, qz, ra, rb, rc, rd, re, rf, rg, rh, ri, rj, rk, rl, rm, rn, ro, rp, rq, rr, rs, rt, ru, rv, rw, rx, ry, rz, sa, sb, sc, sd, se, sf, sg, sh, si, sj, sk, sl, sm, sn, so, sp, sq, sr, ss, st, su, sv, sw, sx, sy, sz, ta, tb, tc, td, te, tf, tg, th, ti, tj, tk, tl, tm, tn, to, tp, tq, tr, ts, tt, tu, tv, tw, tx, ty, tz, ua, ub, uc, ud, ue, uf, ug, uh, ui, uj, uk, ul, um, un, uo, up, uq, ur, us, ut, uu, uv, uw, ux, uy, uz, va, vb, vc, vd, ve, vf, vg, vh, vi, vj, vk, vl, vm, vn, vo, vp, vq, vr, vs, vt, vu, vv, vw, vx, vy, vz, wa, wb, wc, wd, we, wf, wg, wh, wi, wj, wk, wl, wm, wn, wo, wp, wq, wr, ws, wt, wu, wv, ww, wx, wy, wz, xa, xb, xc, xd, xe, xf, xg, xh, xi, xj, xk, xl, xm, xn, xo, xp, xq, xr, xs, xt, xu, xv, xw, xx, xy, xz, ya, yb, yc, yd, ye, yf, yg, yh, yi, yj, yk, yl, ym, yn, yo, yp, yq, yr, ys, yt, yu, yv, yw, yx, yy, yz, za, zb, zc, zd, ze, zf, zg, zh, zi, zj, zk, zl, zm, zn, zo, zp, zq, zr, zs, zt, zu, zv, zw, zx, zy, zz

08626

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08620

1 DECEASED-NAME (Type or Print) <i>Buford Lee Lewis</i>		2a DATE KNOWN OF EST. DEATH <input checked="" type="checkbox"/> Month <i>June</i> Day <i>8</i> Year <i>1967</i>		2b HOUR <i>12:30</i> M
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>1/21/44</i>	6 AGE (In years last birthday) <i>25</i> YRS	7c MONTHS <i>0</i>
7a BIRTH-PLACE (State or foreign country) <i>Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Mechanic</i>
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md</i>		13b COUNTY <i>Mont</i>	13c CITY OR TOWN <i>Rockville</i>	13d INSIDE CITY (Y/N) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME First <i>Sewey</i> Middle <i>Lewis</i> Last <i>Hall</i>		15. MOTHER'S MAIDEN NAME First <i>Nora</i> Middle <i>Hall</i> Last <i>Hall</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO <i>Clony</i>		17 INFORMANT <i>Brother Gary Lewis</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Laceration and Maceration of Brain</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Fracture compound of Frontal lobe of skull</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Trauma</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>73 hr.</i> <i>13 hr.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>11/17 P.M. 6/7 1967</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Struck on Head by Cue Stick</i>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Pool Hall Roys Tavern</i>		21f. LOCATION Street or R.F.D. No. <i>1117 E. Montgomery Ave.</i> City or Town <i>Rockville</i> County <i>Montgomery</i> State <i>Md.</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town, or county) <i>1331 Rockville Pike Rockville, Md.</i>		
23a. BURIAL, CREMATION BY <i>Burial Transit</i>		23b. DATE <i>6/10/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Appalachia, Virginia</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		25a. REC'D BY REGISTRAR <i>Jun 16 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Thomas Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08627

08621

1 DECEASED NAME (Type or print) Mary Ann Loomis			2a. DATE OF DEATH Month 6 Day 29 Year 69			2b. HOUR 9:30 P M								
3 SEX F		4 RACE Caucasian		5. DATE OF BIRTH 7/12/23		6 AGE (In years last birthday) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS M.N. 				
7a BIRTHPLACE (State or foreign country) DN. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md								
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carriage Hill C.C.F. Medical Reclibran		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY						
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE md.				13b COUNTY Montgomery		13c CITY OR TOWN Takoma Park		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5 Grant Ave.				
14. FATHER'S NAME First John Middle Beard Last Scott			15 MOTHER'S MAIDEN NAME First Martha Middle Woodruff Last 			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no			16b. SOCIAL SECURITY NO.			17 INFORMANT Hosp Records Address 		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Retrosstatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF Breast Carcinoma- (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
9a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State				
22a. I certify that (I) (this hospital) attended the deceased from 1964 , 19 , to 6-29-69 19 , that (I) (we) last saw the deceased alive on 6-29-69 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE Robert Kramer MD				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c DATE SIGNED 6/29/69						
22d PHYSICIAN'S NAME (Type) ROBERT KRAMER				22e ADDRESS 8484-16th St - 88. Nd-7										
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE June 30, 1969		23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory				23d LOCATION (City or Town)		(County)		(State) Md.		
24 FUNERAL DIRECTOR John E. Shalters				ADDRESS 254 Carroll St NW				25a. RECD BY REGISTRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE Thomas Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 6 Film 44-11w 08628									
CERTIFICATE OF DEATH									
08622									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Eloise			Carlton			LOVETT			June Month 11 Day 69 Year 1225 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. COUNTY OF DEATH
Female		Caucasian		Dec. 13, 1921			47 YRS		Montgomery Md.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Virginia		USA					Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during rest of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Naval Hospital			housewife			N/A
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Virginia			Fairfax		Springfield		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7323 Charlotte Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Robert G. Carlton			Mary Shepherd						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT				
No			226-16-4586		St. Springfield Address Virginia CDR John F. Lovett, USN, Ret. 7323 Charlotte				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))									
PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Carcinoma of Cervix									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) (OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
22a. I certify that (a) (this hospital) attended the deceased from Feb. 28, 1969, to June 11, 1969, that (b) (we) last saw the deceased alive on June 11, 1969, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
W. M. MURPHY, JR. M.D.									12 June 1969
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
W. M. MURPHY, JR. M.D.					Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		June 13, 1969		Arlington National			Arlington Va.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Demaine Funeral Home					DATE JUN 17 1969		Charles Judge		
Alexandria, Virginia									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
08629					CERTIFICATE OF DEATH					08623				
1 DECEASED NAME (Type or print) DOROTHY W. MAGNUS					2a. DATE OF DEATH JUNE 18 1969					2b. HOJB 23 AM				
3. SEX FEMALE		4 RACE CAUCASIAN			5 DATE OF BIRTH Nov. 25, 1884			6 AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 		
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md						
10. CITY OR TOWN OF DEATH CHEVY CHASE				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BETHESDA-SILVER SPRING N.H.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.				13b. COUNTY 		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3344 MILITARY RD, N.W.				
14 FATHER'S NAME First MOSES Middle Last WOLF					15 MOTHER'S MAIDEN NAME First CLARA Middle Last LIPMAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service) 				16b. SOCIAL SECURITY NO 		17 INFORMANT EDWIN L. DAVIDSON - SON - SAME AS #13 Address 								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Post operative inanition - (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed 2 mos.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ASUS Simultaneous abdominal wall abscess, intestinal obstruction														
19a. DATE OF OPERATION 				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 				21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) 						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.) 				21f. LOCATION Street or R.F.D. No. City or Town County State 						
22a. I certify that (I) (this hospital) attended the deceased from Oct 1968 to 18 June 1969 , that (I) (we) last saw the deceased alive on 4 June 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.														
22b. SIGNATURE Horace W. Bernston DEGREE 				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 18 June '69						
22b. PHYSICIAN'S NAME (Type) HORACE W. BERNSTON				22e. ADDRESS 4743 BRADLEY BLVD, CHEVY CHASE, MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 6-24-1969		23c. NAME OF CEMETERY OR CREMATORY UNION FIELDS CEMETERY				23d. LOCATION (City or Town) (County) (State) BROOKLYN, NEW YORK				
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS				ADDRESS 5130 WISCONSIN AVE, NW WASHINGTON, D.C.				25a. REC'D BY REGISTRAR JUN 23 1969 DATE 		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08630		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08624	
Item 5 Film 44 7/17/69 kk							
1. DECEASED NAME (Type or print) <u>Verlie M. Mahoney</u>				2a. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1969</u>		2b. HOUR <u>5:30 PM</u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>1/8/1908</u>		6. AGE (In years last birthday) <u>61</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Mont.</u>		13c. CITY OR TOWN <u>Rockville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>13963 - Translaka</u>		14. FATHER'S NAME First <u>Robert Franklin</u> Middle <u>Norden</u> Last <u>Walters</u>		15. MOTHER'S MAIDEN NAME First <u>Lucy Belle</u> Middle <u>Walters</u> Last <u>Walters</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16b. SOCIAL SECURITY NO. <u>219-48-4618</u>		17. INFORMANT <u>John Mahoney</u>		Address <u>Spine 49</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congestive heart failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 24</u> , 19 <u>69</u> , to <u>June 26</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>June 26</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James R. Moore</u>				MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>June 27, 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>James R. Moore</u>				22e. ADDRESS <u>570 N. Frederick Ave Gaithersburg Md.</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6/30/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Williamsburg</u>		23d. LOCATION (City or Town) (County) (State) <u>Chester Gap, Virginia</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home Rockville, Md.</u>				13 ADDRESS <u>Rockville Pike</u>		25b. REGISTRAR'S SIGNATURE <u>Richard J. Indel</u>	
25a. REC'D BY REGISTRAR <u>JUN 30 1969</u>							

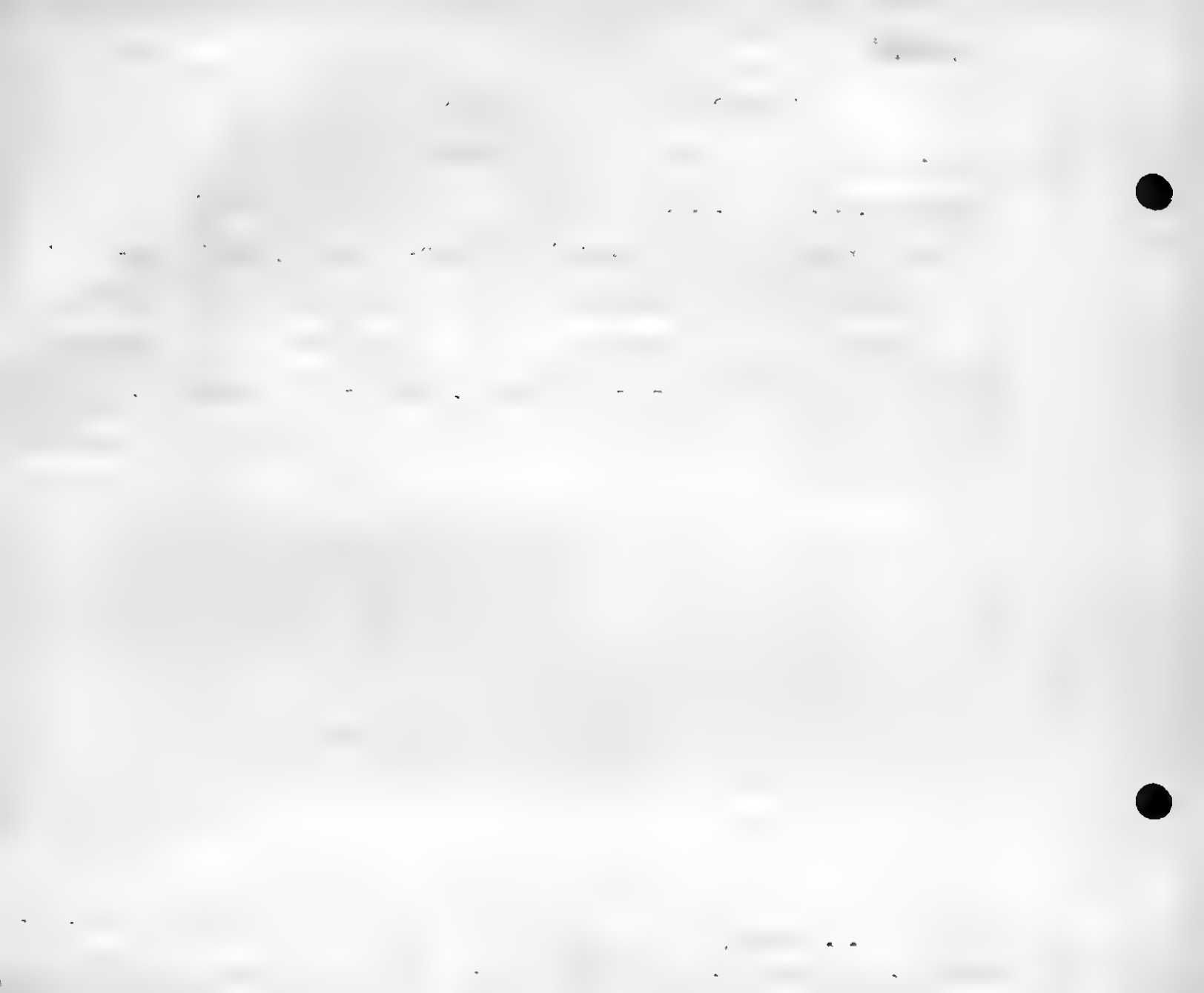
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

2

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												08625 08627			
08631 CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH Month Day Year				2b. HOUR : : AM/PM	
Salvatore				J				Mancuso		6 18 69				3:05 PM	
3 SEX		4. RACE		5 DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Male		White		November 19, 1918				30 YRS.							
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md	
Washington, D.C.				U.S.A.						Montgomery					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring				Holy Cross Hosp.				Route Mgr. Evening Star Newspaper							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Montgomery				Rockville				4905 Arbutus Ave.			
14. FATHER'S NAME				First		Middle		Last		15 MOTHER'S MAIDEN NAME				First Middle Last	
Luciano								Mancuso		Josephine				Chiappone	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT (Name and Address)							
Yes				000 71				579-16-1877				Doris U. Mancuso - 4905 Arbutus Ave., Rockville			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>														minutes	
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>														5 yrs +	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or RFD No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1964, to June 18, 1969, that (I) (we) last saw the deceased alive on June 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.															
22b. SIGNATURE <u>H. C. Maganzini</u>														22c. DATE SIGNED 6/18/69	
22d. PHYSICIAN'S NAME (Type) <u>H. C. Maganzini</u>														22e. ADDRESS <u>520 W. Edmonston Dr. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				June 21, 1969				Gate of Heaven Cemetery				Silver Spring, Montgomery, Md.			
24. FUNERAL DIRECTOR <u>C. G. Carter</u>				ADDRESS <u>8434 Georgia Avenue</u>				25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08632

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08626

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI- MATED		Month		Day		Year		2b HOUR	
CHARLES J. MANNAS								6		5		19		69		1:25 PM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		Month		Day		Year	
Male	White	SEP 28 1896		12 YRS						8		Day		19		69	
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH									
Shippensville Pa		USA		WIDOWED		DIVORCED		Montgomery									
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a LSUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY											
Silver Spring		Holy Cross Hospital		Salesman		Real Estate											
13a LSUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER									
Falls Church Va.		Fairfax		Falls Church		NO		306 S		Virginia Ave.							
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last			
JOSEPH								MANNAS FLORA								UNKNOWN	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS											
yes		WWI				wife Linda		306 S. Virginia Ave.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		Acute Coronary Insufficiency		Arteriosclerotic Heart Disease													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES		NO									
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d INJURY OCCURRED WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASS STANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED									
EXAMINER'S NAME (Type)		Belden R. Reap M.D.		June 5, 1969													
23a BURIAL CREMATION, REMOVAL (Type)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)							
Burial		6/9/69		Glenwood		Baltimore		Md.									
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE											
Carroll J. H.		Baltimore, Md.		JUN 10 1969		J. H. Carroll											



188x

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08633		CERTIFICATE OF DEATH						08627	
1 DECEASED NAME (Type or print) <u>Lawrence C. Mayer</u>			First Middle Last			2a. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1969</u>			2b. HOUR <u>3:40 PM</u>
3 SEX <u>Male</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>6-16-1892</u>			6 AGE (In years last birthday) <u>76</u> YRS		IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) <u>Penn.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery CTy</u>			Md
10 CITY OR TOWN OF DEATH <u>Wheaton, Md.</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Randolph Hills Nsg Home</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Foreman - Chemistry</u>			12b KIND OF BUSINESS OR INDUSTRY <u>Steel Mills</u>	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <u>Florida</u>		13b COUNTY <u>Broward</u>		13c CITY OR TOWN <u>FT. Lauderdale</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>4573 N.W. 17th Terrace</u>	
14. FATHER'S NAME First Middle Last			5 MOTHER'S MAIDEN NAME First Middle Last						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) <u>No</u> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <u>116-03-1047-A</u>		17 INFORMANT <u>Lawrence B. Mayer (Son)</u>			Address <u>7729 Oakwood Dr Derwood, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder.</u> <u>188x</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'lly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>6/9, 1969</u> , that (I) (we) last saw the deceased alive on <u>6/3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>R.C. Macon for S. N. Jones</u>				DEGREE <u>MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>6/9/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Dr. Stephen Jones</u>				22e ADDRESS <u>809 Viers Mill Rd - Rockville, Md.</u>					
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE <u>6/11/69</u>		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>			
24 FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>				ADDRESS <u>1551 Rock Pike, Rockville, Maryland</u>		25 REC'D BY REGISTRAR <u>JUN 11 1969</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First <i>William</i>		Middle <i>R.</i>		Last <i>McCRAY.</i>		2a DATE OF DEATH Month <i>10</i> - Day <i>23</i> Year <i>69</i>		2b HOUR <i>6:45 PM</i>
3 SEX <i>MALE</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>2-24-11</i>		6 AGE (In years last birthday) <i>58</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <i>Kentucky</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery.</i>		Md		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Electronic Eng.</i>		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Kelville</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>12000 Old Georgetown Rd.</i>		
14 FATHER'S NAME <i>John T McCray.</i>		First <i>John</i>		Middle <i>T</i>		Last <i>McCray.</i>		15 MOTHER'S MAIDEN NAME First <i>Bertie</i>		15 MOTHER'S MAIDEN NAME Middle <i>Davis</i>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b SOCIAL SECURITY NO. <i>407-12-5099</i>		17 INFORMANT <i>SARAH M. CRAY</i>		17 INFORMANT Address <i>12000 Old Georgetown.</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Spontaneous massive intra-abdominal hemorrhage</i>										<i>3 hrs</i>
DUE TO, OR AS A CONSEQUENCE OF <i>Splenic infarction due to splenic</i>										<i>3 hours</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>artery thrombosis</i>										
DUE TO, OR AS A CONSEQUENCE OF <i>Acute myocardial infarction, massive</i>										<i>10 days</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 1965, to <i>June 23</i> , 1969, that (I) (we) last saw the deceased alive on <i>June 23</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death										
22b. SIGNATURE <i>William Henry Kelley M</i>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>June 24 1969</i>				
22d. PHYSICIAN'S NAME (Type) <i>William H Kelley</i>		22e ADDRESS <i>5218 Wisconsin Ave Bethesda</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6-27-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Christian Church Cemetery</i>		23d. LOCATION (City or Town) <i>Middletown</i>		County <i>Kentucky</i>		State <i>Kentucky</i>
24 FUNERAL DIRECTOR <i>Robert A Pumphrey</i>		ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>		25a. REC'D BY REGISTRAR <i>JUN 30 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William A. Judge</i>				

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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08635

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08629

1. DECEASED-NAME (Type or Print) DUMLEY DONALD McDONALD			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 20 Year 1969			2b. HOUR 7:15 P.M.	
3 SEX Male	4. RACE White	5. DATE OF BIRTH 2/2/09	6. AGE (in years (last birthday)) 60 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 6 Day 20 Year 1969	
7a. BIRTHPLACE (State or foreign country) Wash., DC		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) H Ly Cross Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Restaurant Manager		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Sp.	13d. INSIDE CITY (A.M.T.S?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 10004 Colesville Rd.	
14. FATHER'S NAME First Thomas A. Middle A. Last McDonald			15. MOTHER'S MAIDEN NAME First Mary Middle C. Last Morton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO 577-24-1875		17. INFORMANT Mrs. Eileen Harold ADDRESS Sil. Sp., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) lost Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED June 20, 1969	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS Bladensburg, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-24-69	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) Bladensburg (County) Maryland			
24. FUNERAL DIRECTOR Francis J. Collins ADDRESS 500 Univ. Blvd. W. Silver Spring, Maryland				25a. REC'D BY REGISTRAR JUN 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



1890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
08630		Item 23 Film 413 6/18/69 kk		08630						
1 DECEASED-NAME (Type or print)			First Middle Last		2a. DATE OF DEATH			2b. HOUR		
James Ductry McNeil					Month 6 Day 5 Year 69			6:55 AM		
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		
M		Negro		6/18/1888		80 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
N. Carolina		USA				Montgomery Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Wheaton			University Nursing Home			Foundry worker				
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Wash., D.C.			V		Washington		YES		82 Tuckerman St. N.W.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma of the kidney</u>								3 yrs		
1890 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from 1-15, 1969, to 6-5, 1969, that (I) (we) last saw the deceased alive on 6-5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED				
Joseph F. Alger, Jr.						6-5-69				
22d PHYSICIAN'S NAME (Type)		22e ADDRESS								
		915 R I Ave N.W. Wash. DC.								
23a BURIAL (CREMATION, REMOVAL) (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		6-9-69		Homewood		Fowler				
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Trayer Home		389 R I - ave N.W.		JUN 11 1969		J. H. Judge				

FOR STATE HEALTH DEPT.

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Items 18a-22a Film 415 MARYLAND STATE DEPARTMENT OF HEALTH
3-11-69 amc DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08637

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08631

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR							
MEXX Gladys Agnes Meadows						X			6 25 1969			2:45							
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Female		White		1-30-25		44 YRS		MONTHS DAYS		HOURS MIN.		Month 6 Day 25 Year 1969		2:45					
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH							
Arkansas				U.S.A.								Montgomery Md.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring				Holy Cross Hos.				Housewife				own home							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INS. OF CITY (AM 15?)				13e. STREET AND NUMBER			
Md.				Montgomery				Sil. Spr.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				3309 Kayson St. Wheaton			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last										
James Grady Smith						Maude Taylor													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT							
no												3309 Kayson Street Mr. Joe P. Meadows Silver Spring, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral hemorrhage																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
				HOUR A.M. P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED											
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				JUNE 25, 1969											
Belden R. Read M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>															
				ADDRESS (Street, city, town, or county)															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				June 1969				Steep Hill Cemetery				Barling, Arkansas							
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Warner P. Smith 8434 Georgia Avenue Silver Spring, Md.				JUN 30 1969				J. L. Lewis, Jr.											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08638

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08632

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR 2:05 P.M.		
CLARENCE			R.			MERCER			6-24 1969		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Year			2d. HOUR
Male	Negro	April 19, 1919	50 YRS					June 24, 1969			2:05 P
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
Md.		U. S. of A.				Montgomery County			Olney		
10. CITY OR TOWN OF DEATH				NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney				Montgomery Gen'l Hospital				Highway Maintenance		State Roads	
3a. USUAL RESIDENCE (Where deceased lived, if admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, WTS?		13e. STREET AND NUMBER	
Maryland				Montg.		Dickerson		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		RFD #2, Big Woods Road	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First Middle Last				First Middle Last							
John Thomas Mercer, Sr.				(deceased)		Rhoda Naomi Onley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
Yes				World War II		x Grace Johnson					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction											
4109 DUE TO, OR AS A CONSEQUENCE OF											
Coronary artery heart disease											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held on death resulted from				Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				2b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				June 24, 1969			
BELDEN R. READ, M.D.				DEPUTY MED. EXAM. <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL				June 27, 1969		Mt. Zion Cemetery		Barnesville, Montg. Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Robert L. Snow				246 N. Washington St. Rockville, Md.				JUN 27 1969			

08639

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08633

1 DECEASED-NAME (Type or print) First Middle Last <i>HELEN OLIVIA MERRETT</i>			2a. DATE OF DEATH Month Day Year <i>6-23-69</i>			2b HOUR <i>1:10 PM</i>	
3 SEX <i>FEMALE</i>		4. RACE <i>CAUC</i>		5 DATE OF BIRTH <i>2-4-90</i>		6 AGE (In years last birthday) <i>79</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>WISCONSIN</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10 CITY OR TOWN OF DEATH <i>Takoma Park</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington San + Hosp</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>SECRETARY</i>		12b KIND OF BUSINESS OR INDUSTRY <i>U.S. GOVT</i>	
13a USUAL RESIDENCE (Where deceased admission) STATE <i>D.C.</i>		13b COUNTY <i>Washington</i>		13c CITY OR TOWN <i>Washington</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <i>OLANS PETERSON</i>		15 MOTHER'S M.A.DEN NAME First Middle Last <i>MATHILDA BEIGER</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>NO</i>		16b SOCIAL SECURITY NO <i>579-50-8787</i>		17 INFORMANT <i>Chart</i>			

18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c))
PART 1 DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

1538

DUE TO, OR AS A CONSEQUENCE OF

Hepatic Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Cause of liver

4 mo

DUE TO, OR AS A CONSEQUENCE OF

Cause of Colon

10 mo

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <i>10mo ago</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca of Colon</i>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year <i>P.M. 19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>68</i> , to <i>JUN 23</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>JUN 18</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b SIGNATURE <i>R. H. Sanderson MD</i>				DEGREE <i>MD</i>		22c DATE SIGNED <i>6-23-69</i>	
22d PHYSICIAN'S NAME (Type) <i>R. H. Sanderson MD</i>				22e ADDRESS <i>7701 Carroll A. TICONE, MD</i>			

23a BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b DATE <i>6/24/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d LOCATION (City or Town) (County) (State) <i>Suitland, MD.</i>	
24. FUNERAL DIRECTOR <i>Jos. Gruber's Sons, Sisco Ave. Av. No</i>				25a REC'D BY REGISTRAR <i>JUN 27 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

425-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 27 hours after death.

Handwritten note: Please mail to State Dept. of Health

08640

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08634

1 DECEASED NAME (Type or print) First Middle Last Rita E. Miller			2a. DATE OF DEATH Month Day Year 6 12 69		2b. HOUR 05 PM
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3/20/11	
7a. BIRTHPLACE (State or foreign country) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton Md.	
14 FATHER'S NAME First Middle Last William E. Lankin		15 MOTHER'S MAIDEN NAME First Middle Last Bessie E. Stang			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 212-03-6903		17 INFORMANT husb/ Carroll V. Miller Address 1803 Franwall Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 3 hr.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>chronic myocardial disease</u> 6 yrs.					
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u>					
19a. DATE OF OPERATION <u>2nd</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 12, 1969</u> to <u>June 12, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 12, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John S. Rogers</u>		22c. DATE SIGNED <u>June 12, 1969</u>		22d. PHYSICIAN'S NAME (Type) John S. Rogers	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 16, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montgomery, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 18 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William E. Pumphrey</u>	

3209

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304A REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
LISA		M		MINIER		6		7 69	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 MONTHS	
F		W		10/19/68		7 12		16	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10	
D.C.		U.S.A.				MONTGOMERY			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS Hosp.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		MONTGOMERY		GATHERSBURG				19100 NORTH KINDLY CT.	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
ROBERT J.		MINIER						Janie Wah Wong	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardio respiratory failure									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Meningitis - organism unknown									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
28 HRS.									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21c. LOCATION		Street or R.F.D. No		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
Anabella MD		6-7-69							
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6-11-69		Williamsport		Williamsport Pa			
24. FUNERAL DIRECTOR		Ernest C. Gartner		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						JUN 12 1969		William J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08642

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08636

1 DECEASED NAME (Type or print) Elizabeth Mitchell			2a DATE OF DEATH 06 Month 29 Day 69 Year			2b. HOUR 7:05M					
3 SEX Female		4 RACE Negro		5. DATE OF BIRTH 08/04/1888		6 AGE (in years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md					
10. CITY OR TOWN OF DEATH Wheaton			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Univ. Nurs. Home 901 Arcola Ave.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Washington			13b CITY OR TOWN D.C.		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3435 Holmead Pl., N.W.				
14 FATHER'S NAME First Middle Last Charles Bowman			15 MOTHER'S MAIDEN NAME First Middle Last Caroline Cope								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown) No			16b SOCIAL SECURITY NO. 578-36-7580		17 INFORMANT DAUGHTER			Address SEE 13b APT. # 615			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Left. Internal Thrombosis with 7 weeks 4339 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Intermedullary Unknown (c) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Degenerative Intestines									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital), attended the deceased from March 1969, to June 1969, that (I) (we) last saw the deceased alive on June 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death											
22b SIGNATURE Henry D. Bell M.D.				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 6/29/69			
22d. PHYSICIAN'S NAME (Type) Henry D Bell, M.D.				22e ADDRESS 3829 14th St. NW Washington, D.C.							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 7.3.69		23c NAME OF CEMETERY OR CREMATORY LINCOLN MEM. CEM.			23d LOCATION (City or Town) SUITLAND, MARYLAND		(County) (State)		
24 FUNERAL DIRECTOR Robert J. McGuire		25a ADDRESS 1820 9TH ST. NW WASHINGTON, D.C.		25b REC'D BY REGISTRAR JUL 1 1969		25c REGISTRAR'S SIGNATURE Charles J. [Signature]					

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

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08643

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

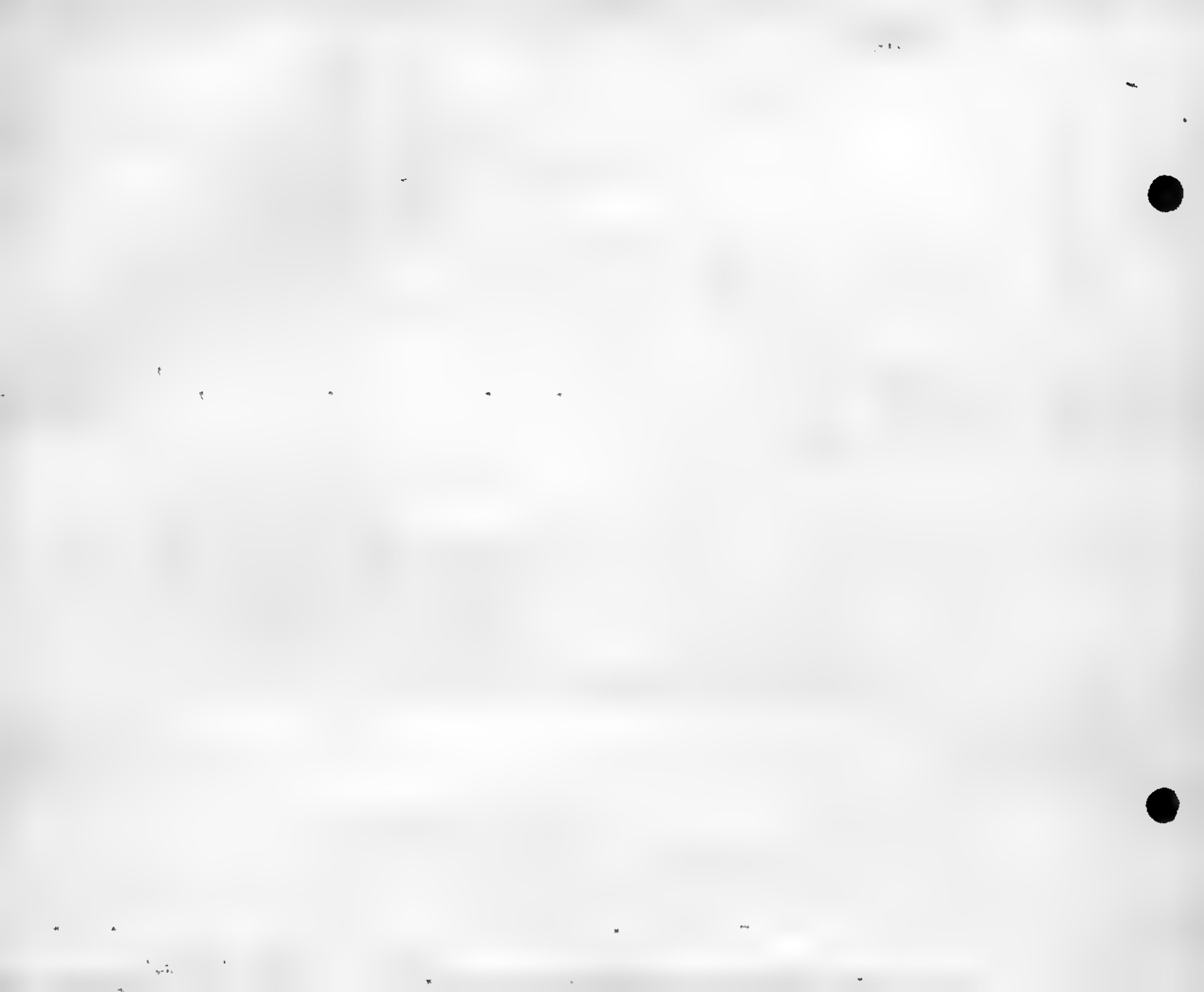
08637

1 DECEASED NAME (Type or Print) John Addison Mohler			2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 6-21 1969			2b HOUR 7:45 P.M.		
3 SEX M.	4 RACE W	5 DATE OF BIRTH 9-7-99	6 AGE (In years last birthday) 69 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN. 0	2c DATE PRONOUNCED DEAD Month June Day 21 Year 1969		
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Real Estate		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY Selling-Appraisal		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 4300 Rosedale Ave.
4 FATHER'S NAME First Jacob Middle Rupert Last Mohler			15. MOTHER'S MAIDEN NAME First Gertrude Middle - Last Hester					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO			17. INFORMANT J. Rupert Mohler ADDRESS Wash. D.C. 1611 Conn Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 Coronary Insufficiency Acute. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Cardio Vascular Disease - (b) Years. (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED June 21, 1969		
EXAMINER'S NAME (Type) John G. Ball			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county) Montgomery Co., Md.								
23a BURIAL, CREMATION REMOVAL (Specify) Cremation		23b DATE 6/25/69		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d LOCATION (City or Town) Suitland, Maryland		(County) (State)
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.				25a. REC'D BY REGISTRAR JUN 26 1969		25b REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR
TERESA		F.		MORIARTY				June 9 1969		6:30 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR		7. UNDER 24 HRS
Female		White		October 30, 1888		80 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
U.S.A. (Mass)		U.S.A.				Montgomery County Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Kensington, Md		Carroll Hall		Homemaker		Own Home				
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Montgomery Co		Bethesda				7110 Exeter Rd Bethesda		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last
Timothy				Moriarty				Mary		Lucey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT						
No		Not Avail.		5516 Oak Place, Mr. William P. Kilmain, Bethesda, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure										
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Hypertensive Cardiovascular Disease										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Gastroenteritis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b)						
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from July 1958, to 6/9, 1969 that (I) (we) last saw the deceased alive on 6/6 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED				
Habeeb Bacchus MD						6/9/69				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
HABEEB BACCHUS, MD		1150 VARNUM STREET, NE WILMINGTON								
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Removal		6-10-69		St. Johns Cemetery		Worcester, Worc. Co. Mass				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
ROBERT A. PUMPHREY, Bethesda, Maryland		7557 Wisconsin Ave		JUN 16 1969		Charles Judge				



FOR STATE
HEALTH DEPT.

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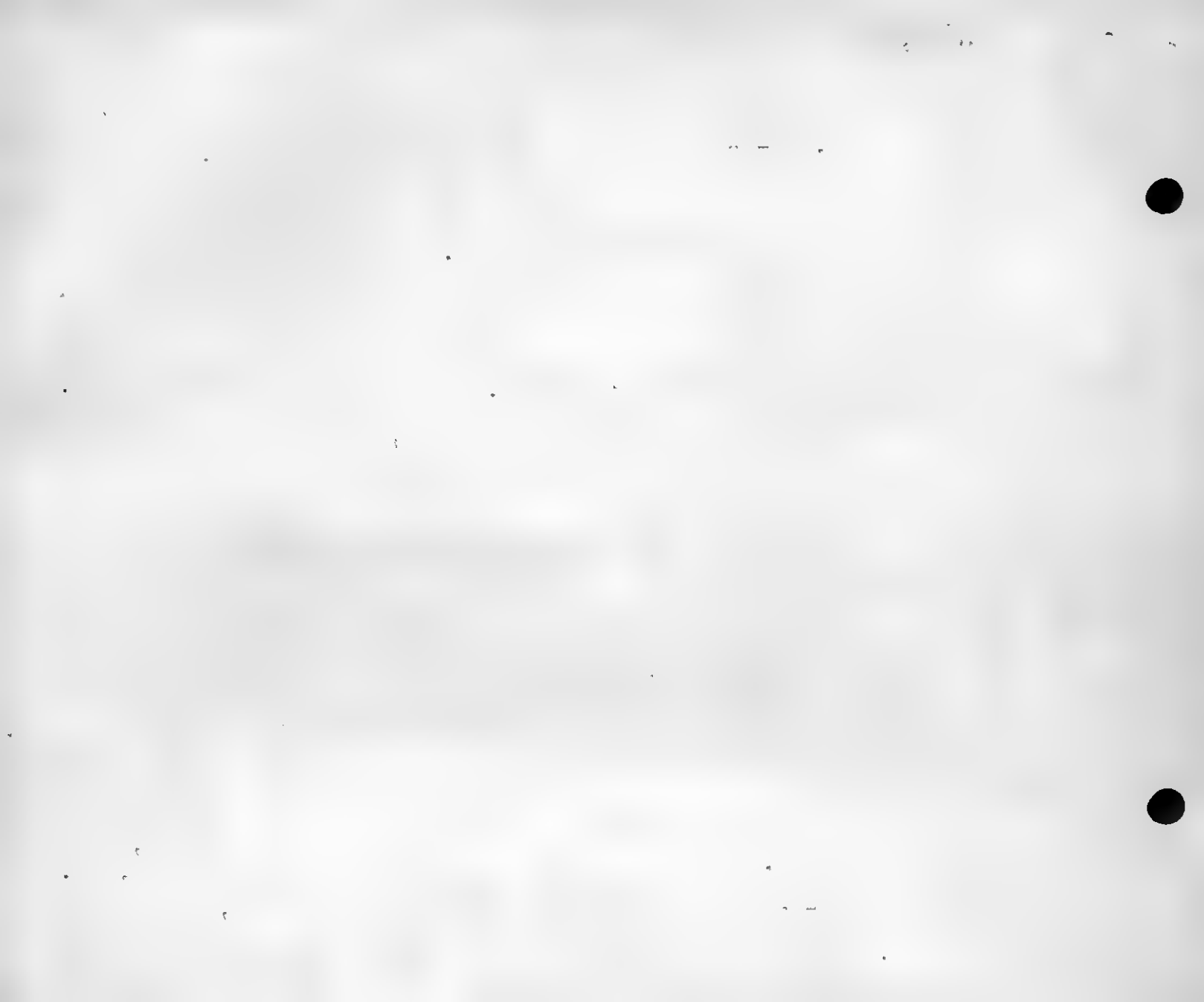
08645

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08639

1. DECEASED NAME (Type or Print) GERTRUDE			First Middle Last ELIZABETH MORRIS			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year June 8, 1969			2b. HOUR 11:30 AM				
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH 6-4-1885		6. AGE (in years last birthday) 84 YRS		7. IF UNDER 24 HRS MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month June 8, Day 1969 Year 1969		2d. HOUR 1:30 PM	
7a. BIRTHPLACE (State or foreign country) England			7b. CITIZEN OF WHAT COUNTRY? England			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8718 Hartsdale Ave.				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUA. RESIDENCE (Where deceased lived, if institution Res dence before adossion) STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8718 Hartsdale Ave.	
14. FATHER'S NAME First Middle Last Thomas Count						15. MOTHER'S MAIDEN NAME First Middle Last Eliza Waring							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO 219-48-0235		17. INFORMANT Daughter ADDRESS Mrs. Philip Kemp				Same as Item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency, acute DUE TO, OR AS A CONSEQUENCE OF (b) Cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Fracture of right wrist										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of right wrist													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 6-1-1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fell down stairs at home					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No 8718 Hartsdale Ave, City or Town Bethesda, State Montgomery Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED June 8, 1969					
EXAMINER'S NAME (Type) JOHN G. BALL				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, c.t.y, town, or county) Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE 6-9-69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						ADDRESS		25a. REC'D BY REGISTRAR JUN 16 1969		25b. REGISTRAR'S SIGNATURE John Charles Judge			

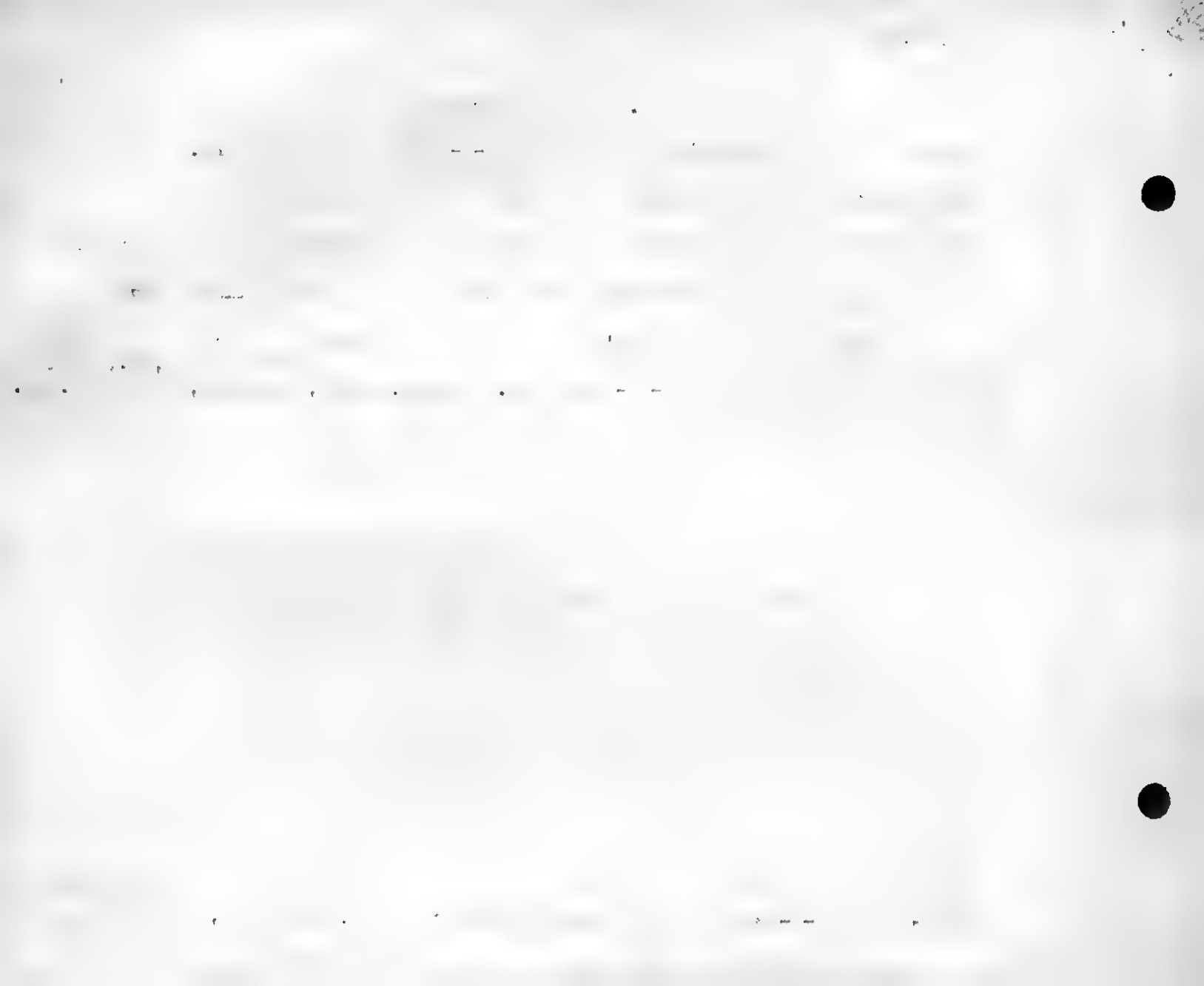


4360

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08646		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08640	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		Hour
Anna		M.		Murphy	June 3, 1969		12 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	7. IF UNDER 1 YEAR
Female		Caucasian		11-7-1886		82 yrs.	MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Massachusetts		United States		Montgomery		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Chevy Chase		4515 Willard Avenue		Housewife		At Home	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Montgomery		Chevy Chase		4515 Willard Avenue	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	
John		Kelly		Bridget		Tully	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Chevy Chase, Md., 20015		PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		(b) <u>Hypertension and</u>					
		(c) <u>arteriosclerosis</u>					
		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1951</u> , to <u>June 1969</u> , that (I) (we) lost the deceased on <u>June 2 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death		22b. SIGNATURE <u>Jerome J. Krick M.D.</u>	
22c. DATE SIGNED <u>6/3/69</u>		22d. PHYSICIAN'S NAME (Type) <u>JEROME J. KRICK</u>		22e. ADDRESS <u>2800 QUEBEC ST., N.W.</u>		22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-6-1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) <u>Colmar Manor, Prince Georges Co Maryland</u>	
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SON, INC.</u>		24a. ADDRESS <u>4130 WISC. AVE., N. W. WASH., D. C. 20016</u>		24b. REC'D BY REGISTRAR <u>JUN 9 1969</u>		24c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



4251

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08647		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08641	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print) <i>Louis</i>		First <i>Naylor</i>		Middle <i>Naylor</i>		Last <i>Naylor</i>	
3 SEX <i>MALE</i>		4 RACE <i>Black Negro</i>		5 DATE OF BIRTH <i>2-4-18</i>		2a. DATE OF DEATH Month <i>6</i> - Day <i>21</i> - Year <i>69</i>	
7a BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 AGE (in years last birthday) <i>50</i> YRS		2b HOUR <i>8:55 PM</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>unemployed</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>MD.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Bryds</i>		13d INS DE CITY - MTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First <i>Arthur</i>		Middle <i>Naylor</i>		Last <i>Naylor</i>		15 MOTHER'S MAIDEN NAME First <i>Helen</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b SOCIAL SECURITY NO		17 INFORMANT <i>Eleanor Payne</i>		Address <i>12018 Bluehill Rd.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>congestive HEART FAILURE</i>						<i>seconds</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>IDIOPATHIC CARDIOPATHY</i>						<i>?</i>	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 <i>69</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>JUNE 11, 1969</i> to <i>JUNE 20, 1969</i> , that (I) (we) last saw the deceased alive on <i>JUNE 20, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (aid not) view the body after death.							
22b. SIGNATURE <i>Robert C. Paddario MD</i>				22c. DATE SIGNED <i>6/22/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>ROBERT C. PADDARIO</i>				22e. ADDRESS <i>3413 CEDAR LANE BETHESDA</i>			
23a. BURIAL, CREMATION REMOVED TO (Specify)		23b. DATE <i>6-25-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Marks Church</i>		23d. LOCATION (City or Town) (County) (State) <i>Boyas, Md. Mt. g.</i>	
24 FUNERAL DIRECTOR <i>Robert L. Snowden</i>		ADDRESS <i>Rockville, Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 25 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Robert L. Snowden</i>	

1



08648

CERTIFICATE OF DEATH

08642

1 DECEASED NAME (Type or print) <u>Joseph H. Oden</u>			2a. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1969</u>		2b. HOUR <u>7:00</u> AM
3 SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH <u>11/8/86</u>		6 AGE (In years last birthday) <u>82</u> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <u>Montgomery</u> Md.		
10 CITY OR TOWN OF DEATH <u>Bethesda</u>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hosp.</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Carpenter</u>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md.</u>	13b. COUNTY <u>Montgomery</u>	13c. CITY OR TOWN <u>Bethesda</u>	13d. INSIDE CITY, M.T.S.P. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>5606-Greentree Rd.</u>	
14 FATHER'S NAME First <u>Richard</u> Middle <u>H.</u> Last <u>Oden</u>	15 MOTHER'S MAIDEN NAME First <u>Mary Ellen</u> Middle <u>Case</u> Last <u>Case</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO <u>579-05-2971</u>	17 INFORMANT <u>Joseph E. Oden</u> <u>5606-Greentree Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-Vascular accident</u> <u>4307</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dehydrated arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>year</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Respiratory infection & coronary heart disease</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR <u>10</u> MIN <u>00</u> Month <u>6</u> Day <u>4</u> Year <u>1969</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1967</u> , to <u>June 4, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>G. B. Hunter</u>	22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED <u>June 4, 1969</u>			
23a. BURIAL CREMATION REMOVED (Specify)	23b. DATE <u>6-6-69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) <u>Bladensburg</u>	(County)	(State)
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u> <u>7557-Wisconsin Ave., Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>MIN</u> DATE <u>9 1969</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

08649 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08643

1 DECEASED NAME (Type or Print) ETNAINE E. OHMAN'S		First Middle Last		2a DATE KNOWN OF DEATH ESTIMATED Month Day Year 6 25 1969				2b HOUR 12 34 PM	
3 SEX Female	4 RACE W	5 DATE OF BIRTH Dec 5, 1919	6 AGE (In years last birthday) 49 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year June 25 1969	
7a BIRTHPLACE (State or foreign country) Illinois		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Bethesda 1204 Mulberry Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife				12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased admission) STATE Penn		13b COUNTRY Allegheny Pittsburgh		13c CITY OR TOWN Pittsburgh		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 937 St James Place	
4 FATHER'S NAME Abel A Dehan		First Middle Last		15 MOTHER'S MAIDEN NAME Edna Conway		First Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT John Ohman's Husband				ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) IPATHYGI Cardiac Arrhythmia 427.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Isupril inhalation DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John G Ball		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED June 25, 1969		ADDRESS (Street, city, town, or county) Bethesda, Md	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE 6/26/69		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d LOCATION (City or Town) (County) (State) Suitland Prince Geo. Md			
24 FUNERAL DIRECTOR Robert A Pumphrey				ADDRESS 7557 Wisconsin Ave Bethesda, Md		25a REC'D BY REGISTRAR DATE JUN 30 1969		25b REGISTRAR'S SIGNATURE John G. Ball	



4123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08650		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08644	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last <i>Joseph HOMER ORME</i>			2a. DATE OF DEATH Month Day Year <i>6-11-69</i>			2b. HOUR <i>6:00 P.M.</i>	
3 SEX <i>MALE</i>		4. RACE <i>White</i>		5 DATE OF BIRTH <i>16-94</i> <i>12-16-94</i>		6 AGE (In years lost birthday) <i>74</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUA. OCCUPAT ON (Kind of work done during last of working, ie, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. USIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <i>Maurice Orme</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>Bertha Smith</i>		13e. STREET AND NUMBER <i>3911 Decatur Ave.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>705-07-8500</i>		17 INFORMANT Address <i>Nancy Stubbs. 3911 Decatur Ave.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary emboli massive</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>due to atherosclerotic heart disease</i>							18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hr.</i> <i>3 months.</i> <i>Undetermined</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>chronic obstructive pulmonary disease</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21b. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21c. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/3/1969</i> to <i>6/11/1969</i> , that (I) (we) last saw the deceased alive on <i>6/11/1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Faruk Ozer</i>				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) <i>FARUK OZER</i>	
22e. ADDRESS <i>1125 Rockville Ave Rockville, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6-14-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		23d. LOCATION (City or Town) (County) (State) <i>Frederick Frederick Md.</i>	
24. FUNERAL DIRECTOR <i>Francis H. Barber Laytonsville, Md.</i>				25a. REC'D BY REGISTRAR <i>JUN 16 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08651

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08645

1. DECEASED-NAME (Type or print) Pearl M. Padgett			2a. DATE OF DEATH Month June Day 28 Year 1969			2b. HOUR 3:40 P.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH 3-4-85		6. AGE (in years lost birthday) 84 YRS.		7. UNDER 1 YEAR MONTHS 8 DAYS 14 HOURS 10 MIN.	
7a. BIRTHPLACE (State or foreign country) Mich.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md.		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Gillespie's Trailer Ct.	
14. FATHER'S NAME First Charles Middle Morse Last Wolfe			15. MOTHER'S MAIDEN NAME First Wolfe Middle Wolfe Last Wolfe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No		16b. SOCIAL SECURITY NO 186		17. INFORMANT Frank Padgett, Waldorf Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF 3 Days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 41 (b) 3 Days DUE TO, OR AS A CONSEQUENCE OF 3 Days (c) 3 Days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia - Terminal									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 6 Day 26 Year 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 6/26/69 City or Town 6/28/69 County 6/28/69 State 6/28/69					
22a. I certify that (I) (this hospital) attended the deceased from 6/26/69 to 6/28/69 , that (I) (we) last saw the deceased alive on 6/28/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE John J. Curry M.D.		22c. DATE SIGNED 6-29-69		22d. PHYSICIAN'S NAME (Type) John J. Curry M.D.		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Rest		23d. LOCATION (City or Town) (County) (State) L3 Plaza, Chas. Md.			
24. FUNERAL DIRECTOR HUNTT FUNERAL HOME - WALDORF, MD.		25a. REC'D BY REGISTRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE William Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08646			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										08652			
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR		
JAMES			W		PALMER				ESTIMATED <input checked="" type="checkbox"/> Month <u>6</u> Day <u>9</u> Year <u>1969</u>		2:57 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years)		7. IF UNDER YEAR		2c. DATE PRONOUNCED DEAD		2d. HOUR	
MALE		N		4/1/97		72 YRS		MONTHS <u>6</u> DAYS <u>9</u> HOURS <u>6</u> MIN <u>57</u>		Month <u>6</u> Day <u>9</u> Year <u>1969</u>		2:57 AM	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland			U.S.A.						MONTGOMERY Md				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING				HOLY CROSS									
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, MILE?		13e. STREET AND NUMBER			
MD.				MONTGOMERY		SILVER S.		YES <input type="checkbox"/> NO <input type="checkbox"/>		3511 EDWIN STREET			
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Pneumococcal pneumonitis; bilateral</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) <u>Hypertensive cardiovascular disease</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH				HOUR A.M. <u>19</u> P.M.									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								City or Town					
								County					
								State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
<u>Belden R. Leep</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				<u>June 9, 1969</u>					
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town or county)					
<u>Belden R. Leep M.D.</u>				<u>Washington</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR					
								JUN 16 1969					
								25b. REGISTRAR'S SIGNATURE					
								<u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4409

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Ray Ammen Palmer						6 Month 17 Day 69 Year			11:45 AM
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		Cauc.		3/28/1878			91 YRS.		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Childress, Va.		USA				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Wheaton			University Nursing Home			Business owner		Merchant	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY L.M.T.S?		13e. STREET AND NUMBER
Md.			Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9502 Thornhill Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Samuel G. Palmer			Martha Ammen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <input checked="" type="checkbox"/> No			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
			1-44-24-8865		Harvey R. Palmer R-518 Hopewell, New Jersey				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac decompensation									1 hr
4409 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis									Many years
Conditional, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		—		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. no City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1961, 19 to June 17, 1969, that (I) (we) last saw the deceased alive on June 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Bennet A. Porter, Jr., M.D.								June 17, 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Bennet A. Porter, Jr., M.D.				9301 Colesville Rd., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		JUNE 1969		HIGHLAND CEM		HOPEWELL, NEW JERSEY			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W.W. CHAMBERS CO		5801 CLEVELAND AVE		JUN 20 1969		J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08654		CERTIFICATE OF DEATH						08648	
1. DECEASED-NAME (Type or print) <i>William Peter Palmer</i>			First Middle Last			2a. DATE OF DEATH Month <i>6</i> Day <i>9</i> Year <i>69</i>			2b. HOUR M
3. SEX <i>MALE</i>	4. RACE <i>White</i>		5. DATE OF BIRTH <i>August 5, 1894</i>			6. AGE (In years last birthday) <i>74</i> YRS.		7. IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery County</i>			Mo.
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>NSG & CONU CENTER</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Carpenter</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>US Govt.</i>	
13a. USUAL RESIDENCE (Where deceased lived/Institution. Residence before admission) STATE <i>DC</i>		13b. CITY OR TOWN <i>District of Columbia</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>508 Rocky Mount Drive</i>			
14. FATHER'S NAME <i>Peter L. Palmer</i>			First Middle Last			15. MOTHER'S MAIDEN NAME <i>Cornelia Ligon</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <i>YES 1913-1918</i>		16b. SOCIAL SECURITY NO		17. INFORMANT <i>Lois Eileen Dove, Daughter</i>			Address <i>5108 Rocky Mount Drive, Hillcrest Heights, Md.</i>		
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>hepatic failure</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>cirrhosis of the liver</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>alcoholism</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. <i>2/19</i>		City or Town <i>69</i>		County <i>6/8</i> State <i>69</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/7</i> , 19 <i>69</i> , to <i>6/8</i> , 19 <i>69</i> , that (I) (we) saw the deceased alive on <i>1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>David A. Morowitz, MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>	
22c. DATE SIGNED <i>6/9/69</i>									
23a. PHYSICIAN'S NAME (Type) <i>DAVID A. MOROWITZ</i>		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/11/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>		
24. FUNERAL DIRECTOR <i>Robert J. Wilkins</i>		ADDRESS <i>4308-Sutton Rd. Suitland, Md.</i>		25a. REC'D BY REGISTRAR <i>John J. Judge</i>		DATE <i>JUN 16 1969</i>		25b. SIGNATURE	



08655

CERTIFICATE OF DEATH

08649

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address) 5500 Prospect Place		e. STREET ADDRESS 5500 Prospect Place	
3. NAME OF DECEASED (Type or print) William A. Pancoast, Jr.		4. DATE OF DEATH June 8 19 69	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1916
9. AGE (in years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY SALESMAN	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William A. Pancoast, Sr.		14. MOTHER'S MAIDEN NAME Myrtle Jacobs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-16-8663	
17. INFORMANT Mrs. Ruth Maxwell (Sister)		Address 2700 Conn. Ave. Wash. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Cerebral arteriosclerosis (a) 3 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) UNDET. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary artery disease with coronary insufficiency			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (first name) attended the deceased from 9-14-65 , 19, to 6-8- , 1969, that (I) (last name) saw the deceased alive on 6-8- , 1969, and that death occurred at 1:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence A. Rapee</i>		22b. DATE SIGNED 6-9-69	
22c. PHYSICIAN'S NAME (Type) Lawrence A. Rapee, M.D.		22d. ADDRESS 106 Irving St. N.W. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/12/69	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.,		25a. REC'D BY REGISTRAR 5130 DOWNS	
25b. REGISTRAR'S SIGNATURE <i>John L. Jones</i>		DATE JUN 12 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08656		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08650	
Item #6, Film 444 7/11 MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH	
Bette Elizabeth Parnell						ESTIMATED MONTH DAY YEAR 6 30 1969	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR	8 IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD	
Female	White	August 1, 1925	44 YRS.	MONTHS DAYS	HOURS MIN	Month Day Year 6 30 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED NEVER MARRIED WIDOWED DIVORCED		9 COUNTY OF DEATH	
Pa.		U.S.A.				Montgomery Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Potomac		River Road		Housewife		At Home	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES NO	
Md.		Montgomery		Bethesda		5710 Durbin Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last				
Lloyd Rhinesmith			Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				Vincent M. Parnell, Husband, Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 758X DUE TO, OR AS A CONSEQUENCE OF (b) Smoke Inhalation + Carbon Monoxide Inhalation DUE TO, OR AS A CONSEQUENCE OF (c) Fire - inside of car 5 min.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES NO	
						YES NO	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
6: 30 6/30 1969		6: 30 6/30 1969		Set on fire gasoline mixture.			
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State			
		Highway in car		River Road Potomac Montgomery Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED	
John S. Ball				ASSISTANT MEDICAL EXAMINER		June 30, 1969	
				DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)	
						Montg. Co., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		7/2/69		Gate Of Heaven Cemetery		Silver Spring, Md.	
24. FUNERAL DIRECTOR				25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JOSEPH GAWLER'S SON, INC.				JUL 7 1969		James Judge	
1800 WISC. AVE., N. W. WASH., D. C.				DATE			

FOR STATE
HEALTH DEPT.

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Items 586 Film 6113
6/19/69 kkk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08651 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08651

1 DECEASED NAME (Type or Print) First <i>Esther</i> Middle <i>Parrott</i> Last <i>Parrott</i>			2a DATE KNOWN OF EST. DEATH Month <i>June</i> Day <i>3</i> Year <i>1969</i>			2b HOUR <i>11:30 PM</i>		
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>8/26/1895</i>	6 AGE (In years last birthday) <i>73</i> YRS	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c DATE PRONOUNCED DEAD Month <i>June</i> Day <i>3</i> Year <i>1969</i>		
7a BIRTHPLACE (State or foreign country) <i>Arkansas</i>		7b CIT ZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md		
10 CITY OR TOWN OF DEATH <i>Kensington</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>10225 Kensington Pkwy</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Kensington</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>10225 Kensington Parkway</i>
14. FATHER'S NAME First <i>Early</i> Middle <i>Clements</i> Last <i>Clements</i>			15 MOTHER'S MAIDEN NAME First <i>Fannie</i> Middle <i>Furlough</i> Last <i>Furlough</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b SOCIAL SECURITY NO <i>213-56-3591</i>		17. INFORMANT <i>Kensington, Maryland</i> <i>Mrs. Arlene Shine (Dan)</i> <i>10225 Kensington Pkwy</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i> DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) (b) <i>Coronary Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>Years</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>June 3, 1969</i>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county) <i>115 National Cemetery, Little Rock, Arkansas</i>								
23a BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b DATE <i>June 6, 1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>U.S. National Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Little Rock, Arkansas</i>		
24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc., Silver Spring, Md.</i>				25a REC'D BY REGISTRAR DATE <i>JUN 10 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

FOR STATE
HEALTH DEPT.

08658

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08658

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
		Fred				Perman				6	1	1969	7:40
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		2c. DATE PRONOUNCED DEAD		Month	Day	Year
Male	Cauc.	4-2-22		47 YRS							6	1	1969
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH							
Wyoming		U.S.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery							
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during usual working life, even if retired.)		12b. TRANSIT INDUSTRY							
Silver Spring		Holy Cross		Bus Operator		Security Guard							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
D.C.				WASHINGTON				2914 Legation St. N.W.					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
JOHN						PERMAN		ANTONIJA				BELOBRAJDIE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NUMBER		17 INFORMANT		ADDRESS							
Yes		189-14-1965		Mary		Perman, 2914 Legation St., Wash							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>John S. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>June 1, 1969</u>					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
				ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
Burial				6-4-1969				Fort Lincoln Cemetery					
23d. LOCATION (City or Town) (County) (State)				23e. REC'D BY REGISTRAR				23f. REGISTRAR'S SIGNATURE					
Washington, D.C.				JUN 9 1969				<u>Charles Judge</u>					
24. FUNERAL DIRECTOR				24a. ADDRESS				24b. ADDRESS					
JOSEPH GAWLER'S SON, INC.				5130 WISCONSIN AVE., N. W. WASH. D. C. 20016									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office. Pages with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08659										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08653																																																																															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																																																																																			
1 DECEASED NAME (Type or Print)										First Middle Last										2a DATE KNOWN OF DEATH										2b HOUR																																																																					
NICHOLAS										LEE										PERRY										Month Day Year 6 24 1969										5 52 A M																																																											
3 SEX										4 RACE										5 DATE OF BIRTH										6 AGE (in years last birthday)										7c DATE PRONOUNCED DEAD										7d HOUR																																																	
M.										W.										10/30/18										50 YRS										Month Day Year 5 June 24 1969										9 45 A M																																																	
7a BIRTHPLACE (State or foreign country)										7b CITIZEN OF WHAT COUNTRY?										8 MARRIED										9. COUNTY OF DEATH																																																																					
West Virginia										U.S.A.										WIDOWED										Montgomery										Md																																																											
10 CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																																																																					
Bethesda										10500 McARTHUR Blvd										Labor										Golf Course																																																																					
13a USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE										13b COUNTY										13c CITY OR TOWN										13d INSIDE CITY LIMITS?										3e STREET AND NUMBER																																																											
Va.										1										VIENNA										YES										2700 OAK Valley Drive																																																											
14. FATHER'S NAME										First Middle Last										15 MOTHER'S MAIDEN NAME										First Middle Last																																																																					
Oliver										R. Perry										Josy										Thomas																																																																					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										(If yes give year or dates of service)										16b. SOCIAL SECURITY NO										17. INFORMANT										ADDRESS																																																											
Yes										WW II										226-12-2644										Georgie King										2700 Oak Valley Dr. Vienna, Va.																																																											
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))										PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF										Years.																																																																					
(c)																																																																																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																																																			
Primary sclerosis diffuse mixed & myocardial fibrosis																																																																																																			
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										YES										NO																																																											
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING										21b TIME OF INJURY Month, Day, Year										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																																																															
CAUSE OF DEATH										HOUR A.M. P.M. 19																																																																																									
21d INJURY OCCURRED										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f LOCATION Street or R.F.D. No										City or Town										County										State																																																	
WHILE AT WORK										NOT WHILE AT WORK																																																																																									
22a. I certify that I took charge of the remains described above, held an Autopsy										Inspection										Inquiry										and in my opinion death resulted from										Natural causes										Accident										Suicide										Homicide										Undetermined manner																			
22a. I certify that I took charge of the remains described above, held an										Autopsy										Inspection										Inquiry										and in my opinion death resulted from										Natural causes										Accident										Suicide										Homicide										Undetermined manner									
ACTUAL SIGNATURE										John B. Ball										M.D.										CHIEF MEDICAL EXAMINER										ASS STANT MED. CAL. EXAMINER										DEPUTY MEDICAL EXAMINER										22b DATE SIGNED										June 24, 1969																													
EXAMINER'S NAME (Type)																																																																																																			
ADDRESS (Street, city, town, or county)																																																																																																			
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town)										(County)										(State)																																																	
Burial										27 June 69										Flint Hill										Oakton, Virginia																																																																					
24 FUNERAL DIRECTOR										ADDRESS										25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE																																																																					
Money & King Funeral Home										Vienna, Virginia										DATE JUN 27 1969																																																																															

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form. PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08660

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08654

1 DECEASED NAME (Type or Print) Richard Michael Peterson		2a DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 6 12 1969		2b HOUR M <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>
3 SEX M	4 RACE W	5 DATE OF BIRTH May 16 1952	6 AGE (In years last birthday) 17 YRS	7c MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery
10 CITY OR TOWN OF DEATH Great Falls		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Potomac River		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME Richard D. Peterson		15 MOTHER'S MAIDEN NAME Maria N. Capacchione		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO		17 INFORMANT Richard D. Peterson
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 6/12 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Drowned when swimming in River.
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Great Falls, River Potomac		21f LOCATION Street or R.F.D. No City or Town County State Great Falls, Potomac - Montgomery Md.
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED June 12, 1969
EXAMINER'S NAME (Type) John G. Ball		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town, or county) 1331 Rockville Pike		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 6/16/1969	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION (City or Town) (County) (State) Silver Spring, Montg. Md.
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Rockville, Md.		25a REC'D BY REG. STRAR JUN 16 1969		25b REGISTRAR'S SIGNATURE Thomas Judge



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) Helen		First K.		Middle Platt		Last		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 6-27-1969		2b. HOUR 10:50	
3. SEX female	4. RACE white	5. DATE OF BIRTH 8-12-41	6. AGE (In years last birthday) 27 YRS	7. UNDER 1 YEAR MONTHS DAYS 	8. UNDER 24 HRS HOURS MIN 	2c. DATE PRONOUNCED DEAD Month 6 Day 27 Year 1969		2d. HOUR M			
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) Longbranch Pkwy S S		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 920 1/2 Longbranch Pkwy			
14. FATHER'S NAME Frank		First Herbert		Middle Utley		15. MOTHER'S MAIDEN NAME Helen		First Urbine			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Carl W. Platt		ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to strangulation DUE TO OR AS A CONSEQUENCE OF with rope, self-inflicted Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 9:00 A.M. 6/27 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) deceased, depressed self in home. (basement)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. City or Town County State 920 1/2 Longbranch Pkwy. Silver Spring Montg. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELOEN R. REAP M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE 6-30-69		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City or Town) (County) (State) Suitland Maryland		22b. DATE SIGNED June 27, 1969			
24. FUNERAL DIRECTOR Francis J. Collins				ADDRESS 500 University Blvd. W. Silver Spring, Md.				25a. REC'D BY REGISTRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE John J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
08662 CERTIFICATE OF DEATH 08656											
1 DECEASED NAME (Type or print) <i>Adolphe G. Pahlman</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>3</i> Year <i>1969</i>			2b. HOUR <i>12:30</i> M					
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>4/10/94</i>		6 AGE (In years last birthday) <i>75</i> YRS		7 UNDER 24 HRS. MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Handcrafter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Handcrafter</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>11909 Seven Locks Rd.</i>		
14. FATHER'S NAME First <i>S. Adolphe</i> Middle <i>Pahlman</i> Last <i>Henrietta</i>			15. MOTHER'S MAIDEN NAME First <i>Schneider</i> Middle <i>Schneider</i> Last <i>Schneider</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service) <i>Army</i>				16b. SOCIAL SECURITY NO <i>226-38-9805A</i>	
16c. INFORMANT <i>A. Taylor Pohlman</i>			16d. ADDRESS <i>11909 Seven Locks Rd., Potomac, Md.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>myocardial infarct</i>											
4107 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<i>Acute gastroenteritis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from <i>June 2, 1969</i> , to <i>June 2, 1969</i> , that (1) (we) last saw the deceased alive on <i>June 2, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death											
22b. SIGNATURE <i>Alfred L. Norton M.D.</i> DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>6/3/69</i>				
22d. PHYSICIAN'S NAME (Type) <i>Alfred L. Norton, Md.</i>					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>6-6-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville, Md.</i>				
24. FUNERAL DIRECTOR <i>Robert A. Humphrey</i> ADDRESS <i>7537-Wis</i>					25a. REC'D BY REGISTRAR DATE <i>JUN 9 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Robert A. Humphrey</i>				

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-133-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

08663

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08657

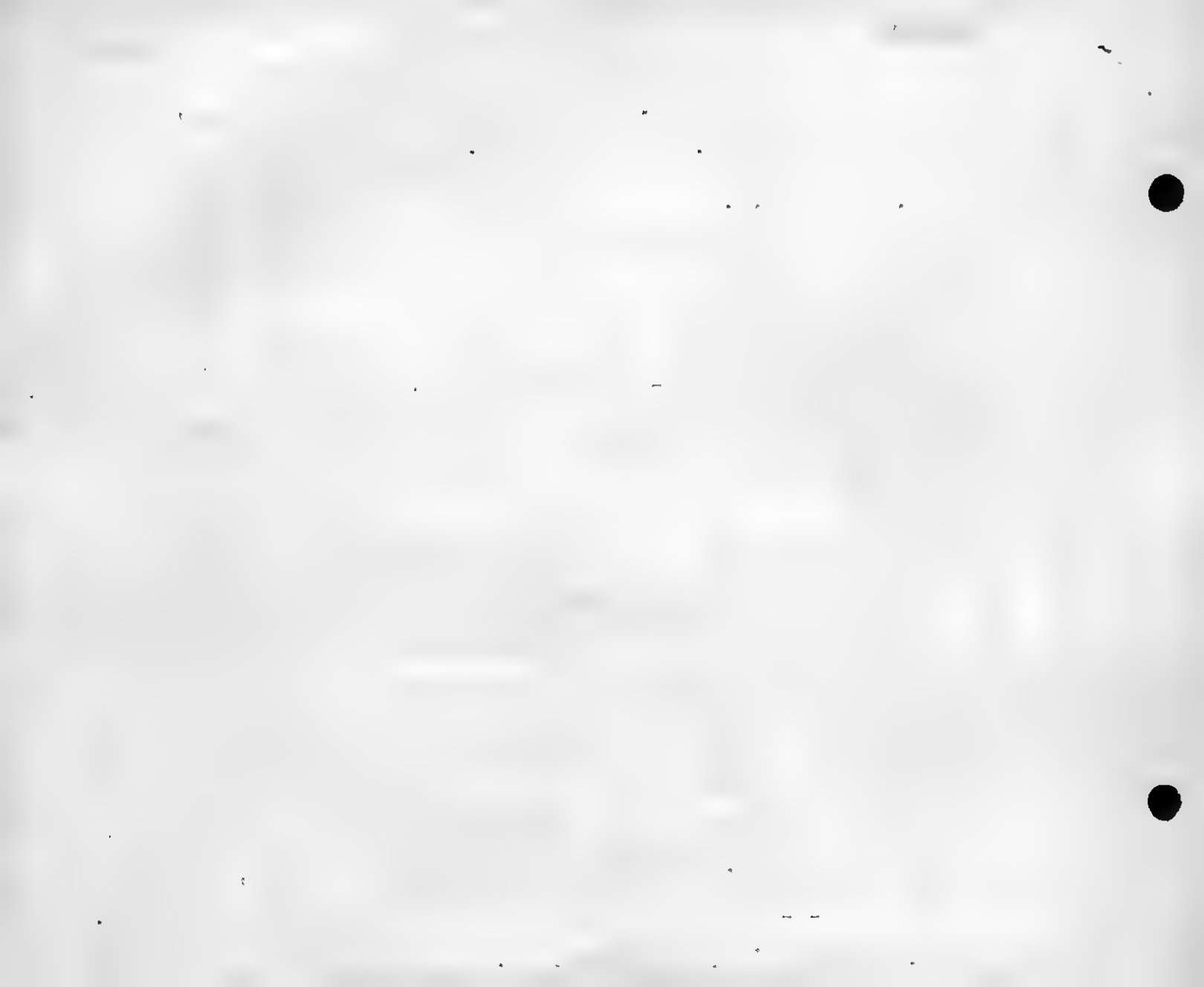
1 DECEASED-NAME (Type or Print) Pauline		First V.		Middle Popson		Last Popson		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 1 Year 1969			2b HOUR 2:30 PM				
3 SEX Female	4 RACE White	5 DATE OF BIRTH 7-20-99	6 AGE (In years last birthday) 68 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0		2c DATE PRONOUNCED DEAD Month 6 Day 1 Year 1969			2d HOUR 2:30 PM				
7a BIRTHPLACE (State or foreign country) Pa.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery									
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.				12a USUAL OCCUPATION (Kind of work done during most of year, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY own home						
13a U.S.A. RESIDENCE (Where deceased lived) STATE Pa.		13b COUNTY Luzerne		13c CITY OR TOWN Ashley		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 15 Manhattan St.							
14 FATHER'S NAME Joseph		First Joseph		Middle Kovatch		Last Kovatch		15 MOTHER'S MAIDEN NAME Susan		First Susan		Middle Kilch		Last unknown	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO 48		17. INFORMANT Edith Popson daughter				ADDRESS 15 Manhattan St. Ashley, Pennsylvania							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Insufficiency Acute. DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State 							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE John S. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED June 1, 1969							
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)											
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE June 5, 1969				23c NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				23d LOCATION (City or Town) (County) (State) Harrover Township Luzerne, Pa.			
24 FUNERAL DIRECTOR Funeral Director E. J. Pumphrey, Inc.				ADDRESS 8434 Lehigh Ave. Silver Spring, Md.				25a REC'D BY REGISTRAR JUN 3 1969				25b REGISTRAR'S SIGNATURE Charles Judge			

43-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08664		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08658	
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
JULIA S. PORTER						June 3, 1969	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	
Female		Cauc.		Nov. 28, 1892		76 YRS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Penna.		U.S.				Montgomery Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Kensington		Kensington Gardens Nursing Home		Housewife			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INS DE CITY LIM TSP	
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15 MOTHER'S M.A.D.E.N NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)		17. INFORMANT	
Clarence Doyle		Martha Gillis		No		11619 Gail Place, Silver Spring, Md.	
16b SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
578-20-3227		AGloria S. Suitor		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))		1 day	
				PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident			
				DUE TO, OR AS A CONSEQUENCE OF (b) Chronic brain syndrome		yes	
				DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis			
				PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 1961 to June 1969, that (I) (we) last saw the deceased alive on June 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED			
		Horace W. Brenton		5 Jun 1969			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE			
Horace W. Brenton		4740 Chevy Chase Drive Chevy Chase, Maryland		Phyllis Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
CREMATION		6-6-69		Cedar Hill Crematory		Suitland Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey		JUN 9 1969		Phyllis Judge			
7557-Wisconsin Ave., Bethesda, Md.							



2761

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

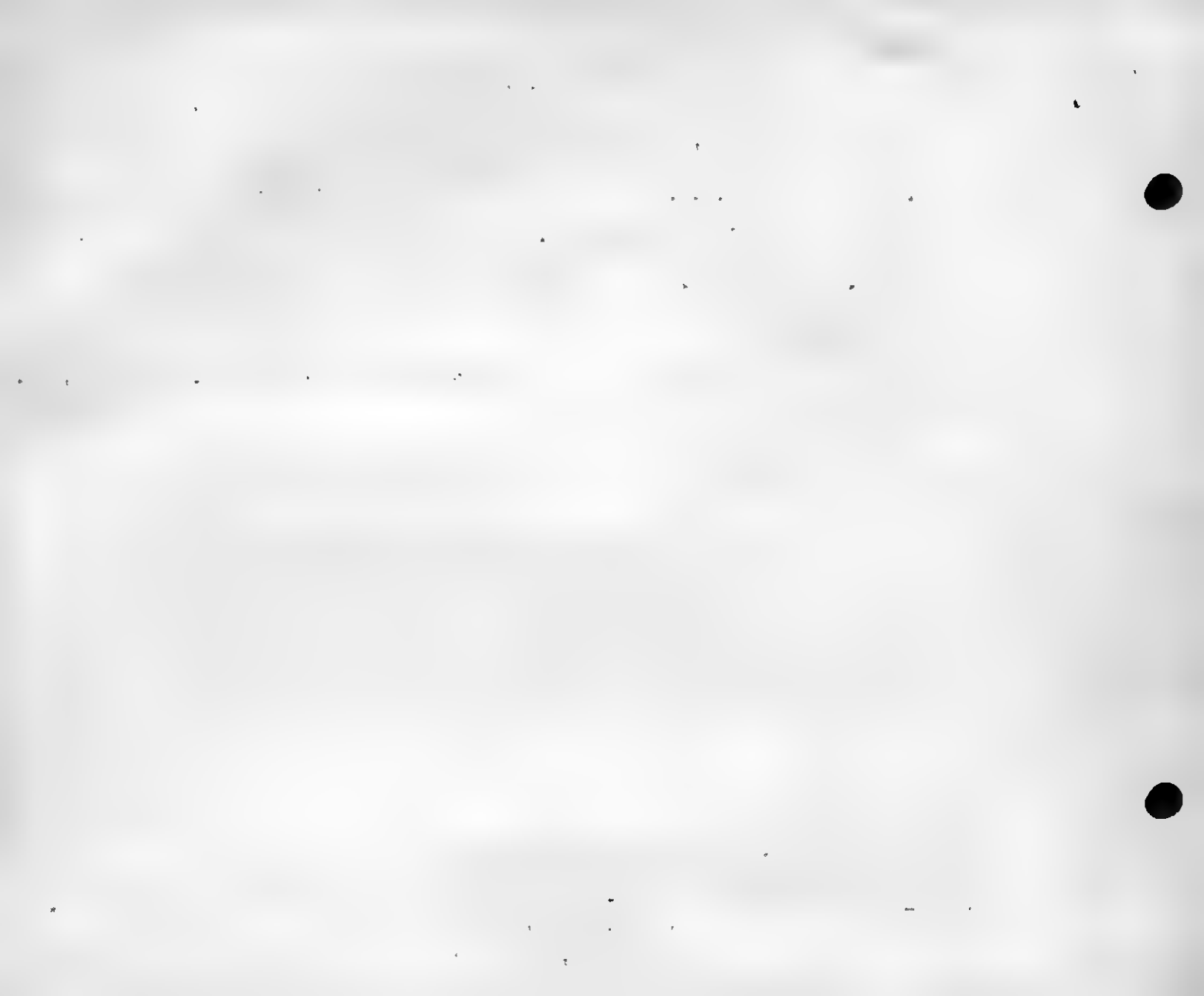
Item 1, Film 413 6/12/69																								
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																								
08665					CERTIFICATE OF DEATH					08659														
1. DECEASED-NAME (Type or print) First <u>Raymond</u> Middle <u>Forest</u> Last <u>Powers</u>					2a. DATE OF DEATH Month <u>June</u> Day <u>8th</u> Year <u>1969</u>					2b. HOUR M <u>11</u>														
3. SEX <u>Male</u>			4. RACE <u>White</u>			5. DATE OF BIRTH <u>Feb 8th 1921</u>			6. AGE (In years last birthday) <u>48</u> YRS.			IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>										
7a. BIRTHPLACE (State or foreign country) <u>W. Va</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Montgomery</u> Md.															
10. CITY OR TOWN OF DEATH <u>Rural Gaithersburg</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>11820 Lermery Rd Gaithersburg</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Painter & Decorator</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>															
13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Montgomery</u>			13c. CITY OR TOWN <u>Gaithersburg</u>			13d. INS. OF CITY, W. TS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13e. STREET AND NUMBER												
14. FATHER'S NAME First <u>Robert F.</u> Middle <u>Powers</u> Last <u></u>					15. MOTHER'S MAIDEN NAME First <u>Laura</u> Middle <u>Belcher</u> Last <u></u>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give year or dates of service) <u>W.W.II</u>					16b. SOCIAL SECURITY NO <u></u>					17. INFORMANT <u>Laura B. Powers</u> Address <u>Rt #3</u> <u>Gaithersburg Md</u>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrotic Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal amyloidosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>6 Months</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Paraplegia, spastic type secondary to Trauma</u>																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)														
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> not while at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>20 July, 1969</u> , to <u>8 June, 1969</u> , that (I) <u>(we)</u> saw the deceased alive on <u>7 June, 1969</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.																								
22b. SIGNATURE <u>Gordon Murdoch Smith, MD</u>										DEGREE <u>MD</u>					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED <u>8 June 69</u>				
22d. PHYSICIAN'S NAME (Type) <u>Gordon Murdoch Smith, MD</u>										22e. ADDRESS <u>Barnesville, Md 20703</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE <u>6-10-69</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>					23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg. Montg. Md.</u>									
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>										ADDRESS <u>Gaithersburg, Md.</u>					25a. REC'D BY REG. STRAR <u>12 1969</u>					25b. REG. STRAR'S SIGNATURE <u>Gordon Murdoch Smith</u>				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)		First Thomas		Middle		Last Prater		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 6 2 1969		2b. HOUR 6:15 P.M.	
3 SEX Male	4 RACE w	5. DATE OF BIRTH Oct 10, 1892		6 AGE (In years birthday) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year June 2 1969		2d. HOUR 6:30 A.M.
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				Md	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 17107 Redland Rd.		12a. JSOA. OCCUPATION (Kind of work done during Farm working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY Farm					
13a. USUAL RESIDENCE (Where deceased lived admission) STATE Md.		13b. CITY OR TOWN Rockville		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER 17107 Redland Road					
14. FATHER'S NAME First Middle Last Unknown		15. MOTHER'S MAIDEN NAME First Middle Last unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO 224 01 7757		17. INFORMANT Lois Mobley		ADDRESS 17107 Redland Rd. Rockville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 * Coronary Insufficiency acute - Sudden DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) * Cardiovascular Disease - years DUE TO, OR AS A CONSEQUENCE OF (c) * Generalized Arteriosclerosis years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED June 2, 1969							
EXAMINER'S NAME (Type) John G. Ball		ADDRESS (Street, city, town or county) 7936 Old Georgetown Rd Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/4/69		23c. NAME OF CEMETERY OR CREMATORY Elizabeth Cemetery		23d. LOCATION (City or Town) (County) (State) Saltville Smith County Va.					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		1331 Rockville Pike Rockville, Maryland		25a. REC'D BY REG. STRAR DATE JUN 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



08667

CERTIFICATE OF DEATH

08661

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M		
Anna Elizabeth Ramsburg						June 16 1969					
3. SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		F UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
F	W		June 25, 1886			82 YRS					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
West Va.			U.S.A.					Montgomery Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Gaithersburg			Asbury Methodist Home, Inc.			Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). STATE			13b COUNTY			13c CITY OR TOWN		13d HAS DE CITY, JM TS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
West Va.						Shepherdstown					
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Benjamin F. Fulk						Gertrude Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT Address					
no			236-56-3338A			Asbury Methodist Home, Gaithersburg, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular thrombosis										1 DAY	
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis										5 YRS.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Multiple myeloma											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (the hospital) attended the deceased from 4/1/69, 19, to 6/16/69, that (I) (we) last saw the deceased alive on 6/16/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNAL RE			22c DATE SIGNED								
Asbury C. Scruggs			6/17/69								
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS								
HENRY C. SCRUGGS MD			5413 Cedar Lane Bethesda MD								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)	
Burial			6-19-69		Elmwood		Shepherdstown W. Va				
24 FUNERAL DIRECTOR			24b ADDRESS			24c REC'D BY REGISTRAR		24d REGISTRAR'S SIGNATURE			
Ernest O. Gartner			Gaithersburg			JUN 20 1969		William L. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08668

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08662

1 DECEASED NAME (Type or Print) <i>First Middle Last</i> <i>Kenneth Henderson Reichard</i>			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <i>6</i> DAY <i>3</i> YEAR <i>1969</i>			2b HOUR <i>5:30</i> MIN <i>M</i>	
3 SEX <i>M.</i>	4 RACE <i>W.</i>	5 DATE OF BIRTH <i>June 28 1908</i>	6 AGE (In years last birthday) <i>60 YRS</i>	IF UNDER 1 YEAR MONTHS <i>11</i> DAYS <i>5</i>	IF UNDER 24 HRS HOURS <i></i> MIN <i></i>	2c DATE PRONOUNCED DEAD Month <i>June</i> Day <i>3</i> Year <i>1969</i>	
7a BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>4903 DuRussey Pkwy</i>		12a USUAL OCCUPATION (Kind of work done during most of work no life even if retired) <i>Car Repair</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Building</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <i>Ernest Reichard</i>		15 MOTHER'S MAIDEN NAME <i>Ina Bowers</i>		ADDRESS <i>Rockville, Maryland 1510 Broadwood Drive</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16b SOCIAL SECURITY NO <i>578-05-9622</i>		17 INFORMANT <i>Kenneth Reichard-son</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction old Recent</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardio Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M. <i></i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town	County
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <i>June 4, 1969</i>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		7936 Old Georgetown Rd., Bethesda, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a BURIAL, CREMATION <i>Burial</i>		23b DATE <i>6/7/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Parklawn Memorial Pk.</i>		23d LOCATION (City or Town) (County) (State) <i>Rockville, Montgomery, Md.</i>	
24 FUNERAL DIRECTOR <i>Tyson Wheeler</i>		1330 Rock. Pike <i>Funeral Home Rockville, Md.</i>		25a REC'D BY REG STRAR <i>JUN 9 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08669

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08663

1. DECEASED-NAME (Type or Print) MRS. CATHERINE ELIZABETH RHOADES		First Middle Last		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 9 Year 1969		2b. HOUR 12:45	
3 SEX F	4 RACE W	5 DATE OF BIRTH 9-20-08	6 AGE (In years and birthday) 60 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 6 Day 9 Year 1969	
7a. BIRTHPLACE (State or foreign country) Mo.		7b. CIT ZEN OF WHAT COUNTRY? U.S. A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. Hosp.		12a. LSJA. OCCUPATION (Kind of work done during last of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USJA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Nebr.		13b. COUNTY Lancaster		13c. CITY OR TOWN Lincoln		13d. INSIDE CITY (L.M. 157) YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Carrie Pratt		First Middle Last		15. MOTHER'S MAIDEN NAME Elsie Williams		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO 506 48 7765		17. INFORMANT Robert Rhoades		5605 39th Ave Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumors, four, DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) meningioma DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held in death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE Belden R. Sharp		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED June 9, 1969	
EXAMINER'S NAME (Type) BELDEN R. SHARP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, Town, or County)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE June 11, 1969		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR F. Gasch8s Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR JUN 17 1969	
				25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then (please) remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08670		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08664		
1 DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JILES				EMMITT	RICHARDS		JUNE 19 69	6:58 a.m.
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER YEAR MONTHS		8 IF UNDER 24 HRS. HOURS M.M.
MALE	WHITE	7-3-05		63 YRS				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
WEST VA.	AMERICAN			MONTGOMERY Md				
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK	WASHINGTON SAN & HOSPITAL		ENGINEER					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER				
MARYLAND	MONTGOMERY	TAKOMA PARK	YES	18 GRANT AVE.				
14 FATHER'S NAME First Middle Last	15 MOTHER'S MAIDEN NAME First Middle Last							
RANSON	RICHARDS		SUZIE HUGHES					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO	17 INFORMANT Address						
NO	333-10-2100	PATIENTS CHART						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute thrombocytopenia with generalized petechial rash involving cerebrum & pons & kidney</u>								10 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of Liver</u>								?
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic nephritis, Hypertension & uremia at time of death</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from <u>4/19/68</u> , 19 <u>68</u> , to <u>6/10/69</u> , 19 <u>69</u> ; that (I) (we) lost saw the deceased alive on <u>6/9/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED		
<u>Howard T. Morse</u>						6/10/69		
22d PHYSICIAN'S NAME (Type)		22e ADDRESS		22f SIGNATURE				
<u>Howard T. Morse</u>		<u>7030 Carroll Ave Takoma Park Md</u>		<u>Arthur Waters</u>				
23a BIRTHPLACE (State or foreign country)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Kentucky		June 13, 1969		Greenlawn Cemetery		Louisiana Kentucky		
24. FUNERAL DIRECTOR		24a ADDRESS		24b REC'D BY REG. STRAR		24c REG. STRAR'S SIGNATURE		
<u>Arthur Waters</u>		<u>254 Calverly St. N.W. Wash. D.C. 20012</u>		JUN 13 1969		<u>Arthur Waters</u>		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

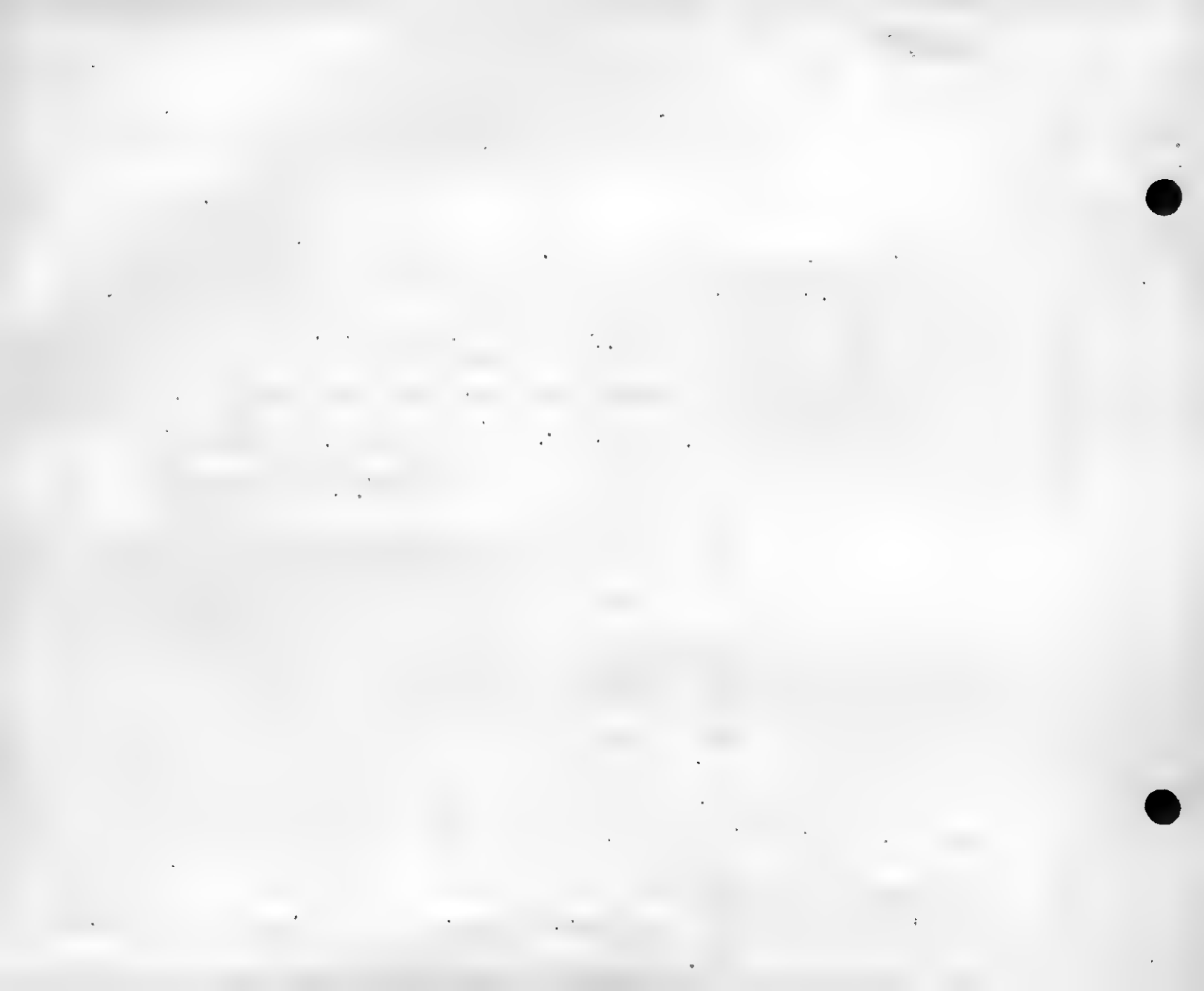
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08665	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										08671	
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOLR		
Chester Edward Rightor						MATED <input checked="" type="checkbox"/> 6 6 1969			99 M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years and birthday)	7 FINGER YEAR	8 FINGER 24 HRS	2c DATE PRONOUNCED DEAD			2d HOUR		
male	white	July 11 1884	82 YRS			Month Day Year			June 6 1969 93 M		
7a BIRTH-PLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md		
Illinois		U. S. A				Montgomery					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban Statisticians									
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.		Mont.		Bethesda				2102 - 5th Parkway			
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Elmer Rightor			Victoria Thompson								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS					
no						Mrs. W.A. Saylor			Above.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Sudden	
DUE TO, OR AS A CONSEQUENCE OF											
+ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										years.	
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22b. DATE SIGNED											
June 6, 1969											
22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street city town, or county)							
John G. Ball				Bethesda, Md.							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY			
Cremation				6-9-69				Cedar Hill Crematory			
24 FUNERAL DIRECTOR				25a REC'D BY REG STRAR				25b REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY, Bethesda, Maryland				JUN 16 1969				John G. Judge			

4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
08672								08666			
1. DECEASED-NAME (Type or print) <u>JOHN</u>			First		Middle <u>C</u>		Last <u>RITTER</u>		2a. DATE OF DEATH Month <u>6-</u> Day <u>27</u> Year <u>1969</u>		
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>12-24-09</u>			6. AGE (In years last birthday) <u>59</u> YRS.		7. UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		
7a. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.					
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Retired U.S. Govt.</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>10908 Bucknell Drive</u>		
14. FATHER'S NAME First <u>CARL</u> Middle <u>D.</u> Last <u>RITTER</u>			15. MOTHER'S MAIDEN NAME First <u>CATHERINE</u> Middle <u>DONOVAN</u> Last <u></u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <u>no</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <u>578-14-2833</u>		17. INFORMANT Address <u>Mrs. Mary B. Ritter Same as #13</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>Auto</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> <u>5 days</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 27, 1969</u> , to <u>June 27, 1969</u> , that (I) (we) lost saw the deceased alive on <u>June 27, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. J. Vosger, M.D.</u>		DEGREE <u></u>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>June 27, 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>3701 Mass. Ave., N. W.</u> <u>Washington, D. C. 20015</u>		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-1-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>					
24. FUNERAL DIRECTOR <u>Francis J. Collins</u> ADDRESS <u>500 Univ. Blvd. W. Silver Spring, Maryland.</u>						25a. REC'D BY REGISTRAR DATE <u>JUL 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



777X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

08673

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08667

1 DECEASED NAME (Type or print) CLAY Bradford ROBINSON			2a DATE OF DEATH Month JUNE Day 27 Year 1969			2b HOUR 6:00 P.M.	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH JUNE 27, 1969		6 AGE (In years last birthday) YRS	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Takoma Pk		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 8304 Garland Ave		14 FATHER'S NAME First Tommy Middle Clay Last Robinson		15 MOTHER'S MAIDEN NAME First Betty-Jeanne Middle Robinson Last Robinson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17 INFORMANT Mother		Address as above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 1177X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) (Office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6/27/69 , 19____, to 6/27/69 , 19____, that (I) (we) saw the deceased alive on 6/27/69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Stanley H. Steinberg, M.D.				DEGREE MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/27/69	
22d PHYSICIAN'S NAME (Type) STANLEY H. STEINBERG, M.D.				22e ADDRESS 731 UNIVERSITY BLVD., E., SILVER SPRING, MD.			
23a B. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 7/2/69		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION (City or Town) (County) (State) Silver Spring, Mont. Md.	
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 131 Rock. Pike		25a REC'D BY REGISTRAR JUL 7 1969	
				25b REGISTRAR'S SIGNATURE William Judge			

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

08674										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08666																																							
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last DONALD H. ROBINSON										Month Day Year June 30 1969										5 ⁴⁴ A M																																							
3 SEX male										4 RACE white										5 DATE OF BIRTH 5/5/15										6 AGE (in years last birthday) 54 YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Tenn										7b. CITIZEN OF WHAT COUNTRY? USA										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH Montgomery										Md																			
10 CITY OR TOWN OF DEATH BETHESDA										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Editor										12b. KIND OF BUSINESS OR INDUSTRY National Assoc. of Manufacturers																													
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Maryland										13b. COUNTY Montgomery										13c. CITY OR TOWN Bethesda										13d. NS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 5313 Glenwood Road																			
14 FATHER'S NAME First Middle Last UNKNOWN										15 MOTHER'S MAIDEN NAME First Middle Last Mildred Johnson																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes										16b. SOCIAL SECURITY NO 1941-45 410-09-6087										17 INFORMANT Julia Robinson - wife										Address - Add. name																													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Broncho-esophageal fistula</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma, left lung</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6/24/69 6/23/69 1 year June 1968																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Radiation fibrosis, mediastinum left upper lobe lung.</u>																																																											
19a. DATE OF OPERATION June 68										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. of lung (epidermoid)										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES																													
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 6/24/69 19 to 6/29/69 19, that (I) (we) saw the deceased alive on 6/29/69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																																																											
22b. SIGNATURE Edward S. Witowski M.D.										DEGREE M.D.										ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED 6/30/69																													
22d. PHYSICIAN'S NAME (Type) EDWARD S. WITOWSKI JR. M.D.																				22e. ADDRESS SUITE 400 8218 WISCONSIN AVE. BETHESDA MARYLAND 20014.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 7-1-69										23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL										23d. LOCATION (City or Town) (County) (State) SUITLAND MD.																													
24. FUNERAL DIRECTOR HANTON FUNERAL HOME - WASH DC										ADDRESS										25a. REC'D BY REGISTRAR JUL 7 1969										25b. REGISTRAR'S SIGNATURE Oplindas Judge																													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Willis			Bruff Robinson			June 18, 1969			11:50 PM
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
Male	Caucasian		March 28, 1896			93		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland USA		USA				Montgomery County, Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Lot 9, 110 Penn Home 12325 New Hampshire Ave.		Electrician		Electrician			
13a U.S.A. RESIDENCE (Where deceased lived, if institut on Residence before adm ss on) STATE		13b CO NY		13c CITY OR TOWN		13d INS-OR CITY, N.Y.S?		13e STREET AND NUMBER	
Maryland		MONTGOMERY		Hyattsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 144, Rt. 216	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William J. H. Robinson			Caroline Wrightson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
No				Daughter		P.O. Box 144, Rt. 216, Hyattsville, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular fibrillation									
4123 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								(b) Anterior wall MI	
DUE TO, OR AS A CONSEQUENCE OF								(c) 20 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Generalized arteriosclerosis - severity									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR AM Month Day Year P.M. 19							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (the hospital) attended the deceased from 4/30, 1969, to 6-18, 1969, that (I) (we) lost saw the deceased alive on 6-18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED							
R.H. Sandstrom M.D.		6-19-69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
R.H. Sandstrom M.D.		7701 Carroll Ave Takoma Park Md							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6-21-69		George Washington Cem.		Hyattsville, Maryland			
24 FUNERAL DIRECTOR		ADDRESS		25a RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY, Bethesda, Maryland				DATE JUN 24 1969		Phonology Judge			



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMB. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08676

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08670

1. DECEASED NAME (Type or Print) TERRY LEE Rodehafer			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 10 Year 1969			2b. HOUR 1:15 PM		
3. SEX MALE	4. RACE W	5. DATE OF BIRTH 10-31-48	6. AGE (in years last birthday) 20 YRS	7. UNDER 1 YEAR MONTHS 0 DAYS 0	8. UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month June Day 10 Year 1969		
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda 495 + 270 Highway		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) STATE OHIO COUNTY NEW CARLISLE		13b. CITY OR TOWN NEW CARLISLE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 203 FRAYNE DR.		
14. FATHER'S NAME First DALE Middle J Last RODEHAFFER			15. MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b. SOC. A. SECURITY NO. 286-44-3558		17. INFORMANT DALE J. RODEHAFFER ADDRESS 203 FRAYNE DR. NEW CARLISLE, OHIO			
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries Severe								Sudden
DUE TO, OR AS A CONSEQUENCE OF (b) Trauma - Auto Accident -								
DUE TO, OR AS A CONSEQUENCE OF (c) 816.1								
Cond it ions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 10 June 10 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Passenger in car went out of control				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f. LOCATION Street or RFD No 495 + 270 Highway		City or Town Bethesda		State Montgomery Md
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John G. Ball		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED June 10, 1969
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-14-69		23c. NAME OF CEMETERY OR CREMATORY NEW CARLISLE CITIZENS Cem		23d. LOCATION (City or Town) (County) (State) NEW CARLISLE OHIO		
24. FUNERAL DIRECTOR W W CHAMBERS CO ADDRESS 1400 CHAPIN ST. WASH. D C				25a. REC'D BY REGISTRAR JUN 16 1969		25b. REGISTRAR'S SIGNATURE Richard Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08677		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08671	
Item 13 Film 414 7/15/69 kk					
1. DECEASED NAME (Type or print)			First Middle Last		2a. DATE OF DEATH
Gertrude Frances Roeder					Month Day Year 4:05 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. UNDER 24 HRS
Female	White	March 25, 1905		64 YRS	MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Virginia	America		Montgomery Md		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington San + Hosp.		Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INS DE CITY, LIM 15?	13e. STREET AND NUMBER	
Maryland	Montgomery	Takoma Park	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7803 Glenside Drive	
14. FATHER'S NAME First Middle Last		15. MOTHER'S M A DEN NAME First Middle Last			
Henry I King		Gertrude A Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war & dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Name Address	
no		219-54-9131		James E. Roeder 7803 Glenside Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>subarachnoid hemorrhage</u>					
DUE TO, OR AS A CONSEQUENCE OF <u>hypertension</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerosis</u>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 6/15/69 to 6/27/69, that (I) (we) last saw the deceased alive on 6/26/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <u>W. H. Volation</u>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) <u>W. H. Volation</u>	
22e. ADDRESS <u>831 Union Blvd. S.</u>					
23a. B. RIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial	June 30, 1969	Cedar Hill Cemetery		Suitland, Maryland	
24. FUNERAL DIRECTOR <u>P. Smith</u>		434 Georgia Avenue		25a. REC'D BY REGISTRAR <u>JUL 2 1969</u>	
Warner E. Pumphrey, Inc., Silver Spring, Md.				25b. REGISTRAR'S SIGNATURE <u>James E. Roeder</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08678

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08672

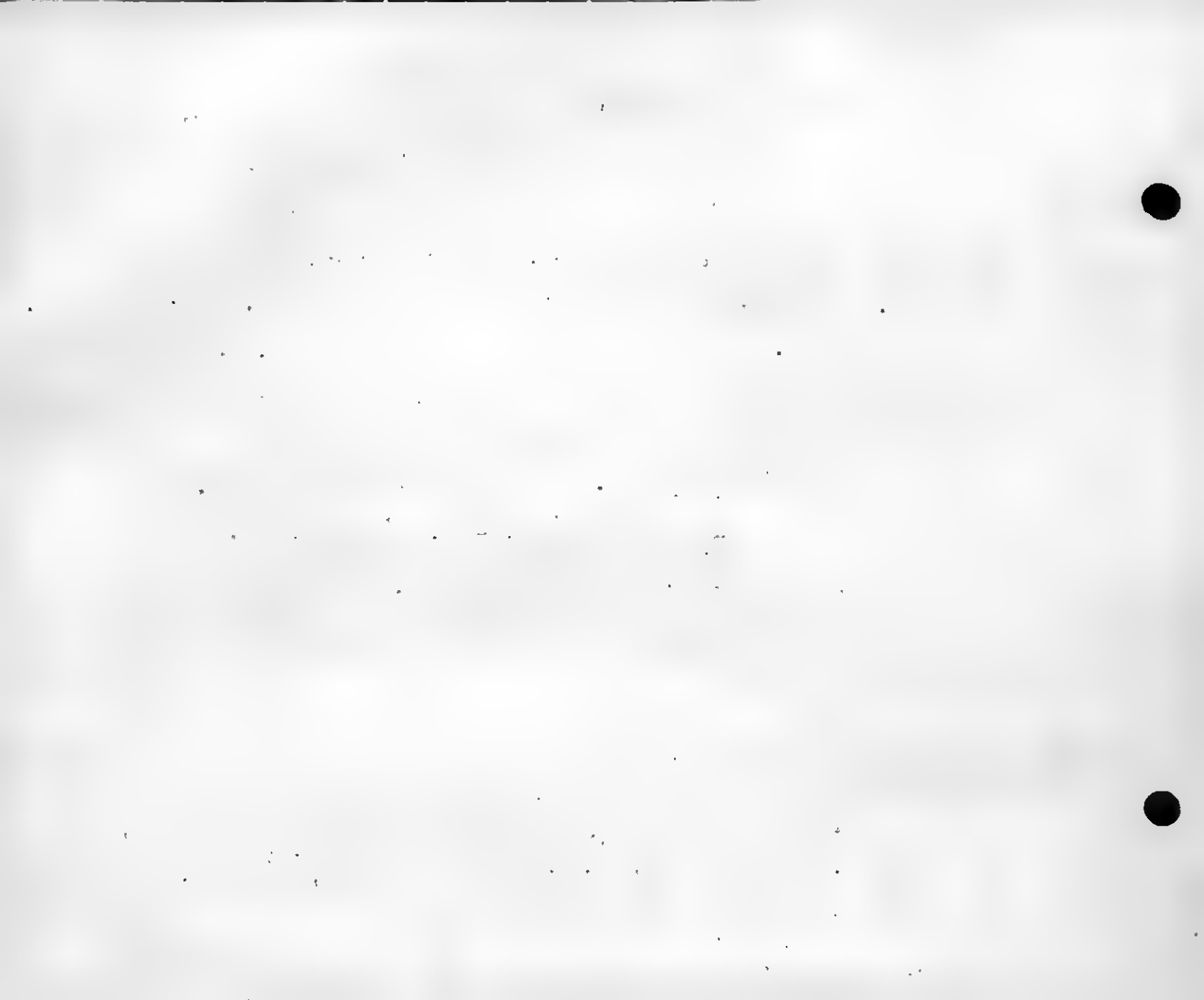
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
Kenneth						Roland		ESTIMATED 6-6-69		1009 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF LATER YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR			
MALE	White	1-26-13	56 YRS	MONTHS	DAYS	Month June Day 6 Year 1969		1013 PM			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
New Jersey		U. S. A				Montgomery					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of workable life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban		SAWAD CHIEF, COUNTRY CLUB							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d AS DE CITY LIM 157		13e STREET AND NUMBER			
D.C.		14		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		619 N.E. Avenue S.E.			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
UNKNOWN								UNKNOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
No				SHIRLEY ROLAND - SAME AS #13							
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary Insufficiency Acute		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		Sudden			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		Cardio Vascular Disease		years.					
		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)							
		19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John B Ball		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)						ADDRESS (Street, city, town, or county)		22b DATE SIGNED		June 6, 1969	
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Cremation		6/8/69		Lee's Crematory		Washington		D. C.			
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
J. Wm. Lees Sons, Co., Washington, DC				JUN 9 1969		Charles Judge					

4122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

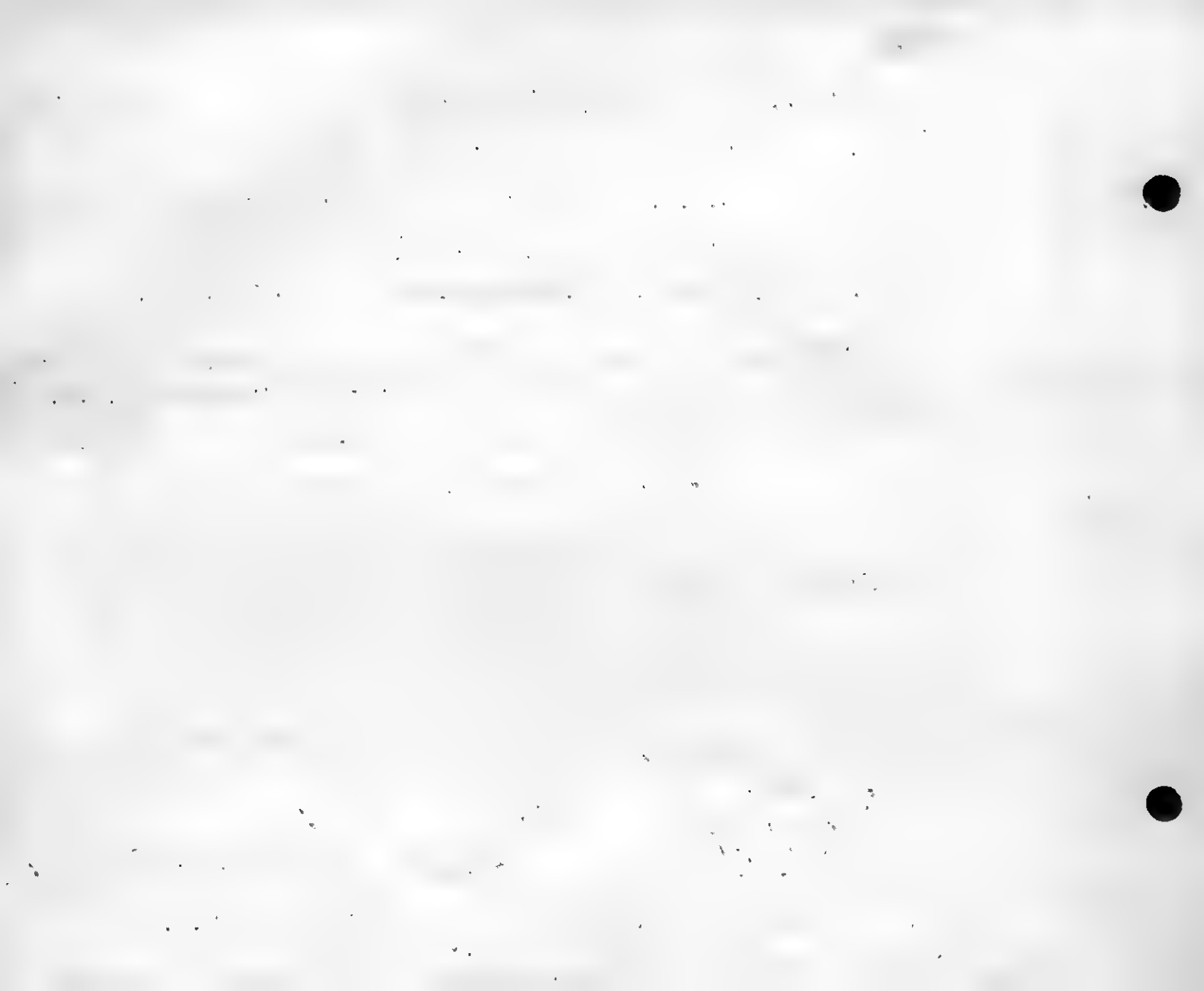
08673				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08673			
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR			
Bertha Elizabeth Rubel				June 29, 1969				4:13 P.M.			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (n years last birthday)		F. UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		April 13, 1890		79 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md.		USA				Montgomery				Md.	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Olney		Montgomery Gen. Hospital		Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - W.T.S?		13e. STREET AND NUMBER			
Md.		Montgomery		Boysds		YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 45, White Grounds Rd.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Thomas L. Zittles				Mary E. Shoemaker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
						Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cerebral Thrombosis								May 28, 1969			
41 DUE TO, OR AS A CONSEQUENCE OF								10 years ?			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Advanced Arteriosclerotic Cardiovascular Disease											
DUE TO, OR AS A CONSEQUENCE OF with Hypertension, marked calcification of multiple arteries - esp. abdominal aorta, aneurysm of the arch of the aorta											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Terminal broncho-pneumonia last 24 hours.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to June 29, 1969, that (I) (we) last saw the deceased alive on June 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
M. McKendree Boyer, M.D.										June 30, 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
M. McKendree Boyer, M.D.				9701 Church Street Damascus, Maryland.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		7/2/69		Boysds Presbyterian		Boysds Montg. Md.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Constance C. Hilton Barnesville Md.				7 1969				Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH	
FANNIE		RUSSAKOFF						6 18 1969 755A M	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR	
Female		W		Feb. 188		88 YRS.		MONTHS DAYS HOURS M.N.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Russia		U.S.A.				Montgomery		Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Hebrew Home of Aged							
13a. USUAL RESIDENCE (Where deceased lived, if "institution" Residence before admission) STATE		13b. CITY OR TOWN		13c INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.		Pr. Georges W. Hyattsville				6615 24th Ave.			
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
Unk								Unk	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		18a. 91421 Springhill		Md	
				Gerald Russ, Grandson, Greenbelt					
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4377				Arteriosclerosis, cerebral				10 yrs	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b) Arteriosclerosis, generalized				15 yrs	
				(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Osteoporosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sep. 20, 1960, to June 18, 1969, that (I) (we) last saw the deceased alive on June 18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		HEINZ J. LORGE		M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		Heinz J. Lorge		22e ADDRESS		Hebrew Home of Greater Washington, Rockville			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/20/69		Mt. Hebron Cem.		Flushing, N.Y.			
24 FUNERAL DIRECTOR		Bernard Danzansky & Sons		3501 14th St. NW Wash. D.C. 20010		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						JUN 23 1969		Charles J. J...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08681

Item 6 Film 413 6/18/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

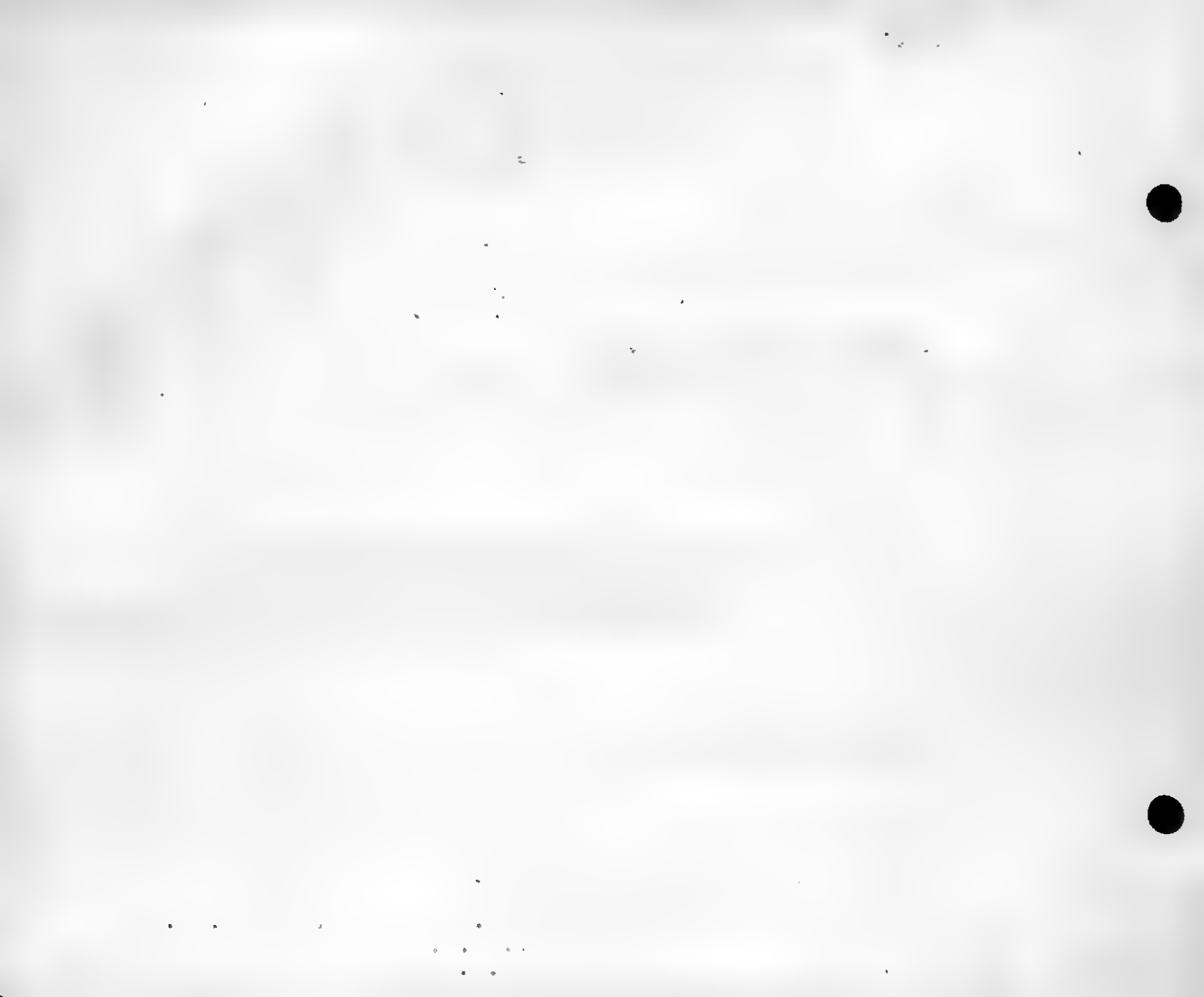
08675

1 DECEASED-NAME (Type or print) <i>Harry</i> First Middle Last <i>Sacks</i>		2a. DATE OF DEATH Month <i>June</i> Day <i>8</i> Year <i>1969</i>		2b. HOUR <i>4:15</i> M
3 SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>Oct. 14, 1881</i>		6. AGE (In years last birthday) <i>87</i> YRS.
7a. BIRTHPLACE (State or foreign country) <i>Rutland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <i>grocer</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>md.</i>	13b. COUNTY <i>mont.</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INS. DEATH LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>6121 - Montrose Rd.</i>
14. FATHER'S NAME <i>Alvin</i> First Middle Last <i>Sacks</i>	15. MOTHER'S MAIDEN NAME <i>Freda</i> First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>no</i> (if yes give war or dates of service)	16b. SOCIAL SECURITY NO. <i>878-46-7394</i>	17. INFORMANT <i>Nora Stern</i> Address <i>4501 Conn. Ave. N.W. Wash. D.C. 20014</i>		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction, old and recent</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary thrombosis, old and recent</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary arteriosclerosis, severe</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>old</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Congestive heart failure.</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>June 3, 1969</i> , to <i>June 8, 1969</i> , that (I) (we) last saw the deceased alive on <i>June 8, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death				
22b. SIGNATURE <i>Sidney J. Cohen</i> M.D.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>June 9, 1969</i>	
22d. PHYSICIAN'S NAME (Type) <i>Sidney J. Cohen, M.D.</i>		22e. ADDRESS <i>50 G. Edmundson Dr., Rockville, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>6/10/69</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cem. of D.C. Lodge</i>	23d. LOCATION (City or Town) (County) (State) <i>D.C.</i>	
24. FUNERAL DIRECTOR <i>Bernard Danzansky & Sons</i>		ADDRESS <i>3501 14th St. N.W. Wash., D.C.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 - Grave Pages 1, 2, and 3. The original of this certificate should be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) x SANDERS			First NAMES			Middle MARVIN			Last		
2a DATE KNOWN OF DEATH		Month 6		Day 27		Year 1969		2b HOUR 6:24		M M	
3 SEX MALE		4 RACE NEGRO		5 DATE OF BIRTH 5/17/29		6 AGE (In years last birthday) 40 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS		IF UNDER 24 HRS HOURS 0 MIN	
7a BIRTHPLACE (State or foreign country) N. CAROLINA		7b CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md					
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MAINTENANCE MAN			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD.			13b COUNTY Montgomery			13c CITY OR TOWN Silver Spring			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 1954 Rosemary Hills Dr.											
14 FATHER'S NAME First WALTER Middle NMI Last SANDERS			15 MOTHER'S MAIDEN NAME First LILIAN Middle NMI Last AUSTIN								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO 246 344-9126			17. INFORMANT MRS. LOU SANDERS			ADDRESS SAME		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe fatty metamorphosis of liver;											
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral fat embolization											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED June 27, 1969			
EXAMINER'S NAME (Type) BELDEN R. REAP MD.		ADDRESS (Street, City, Town, or County)									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/3/69		23c. NAME OF CEMETERY OR CREMATORY REST HEVEN CEM.		23d. LOCATION (City or Town) WILSON, N. C.		(County)		(State)	
24. FUNERAL DIRECTOR Robert E. Reap		1820 5TH ST., N.W.		WASHINGTON, D.C.		25a. REC'D BY REGISTRAR JUL 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



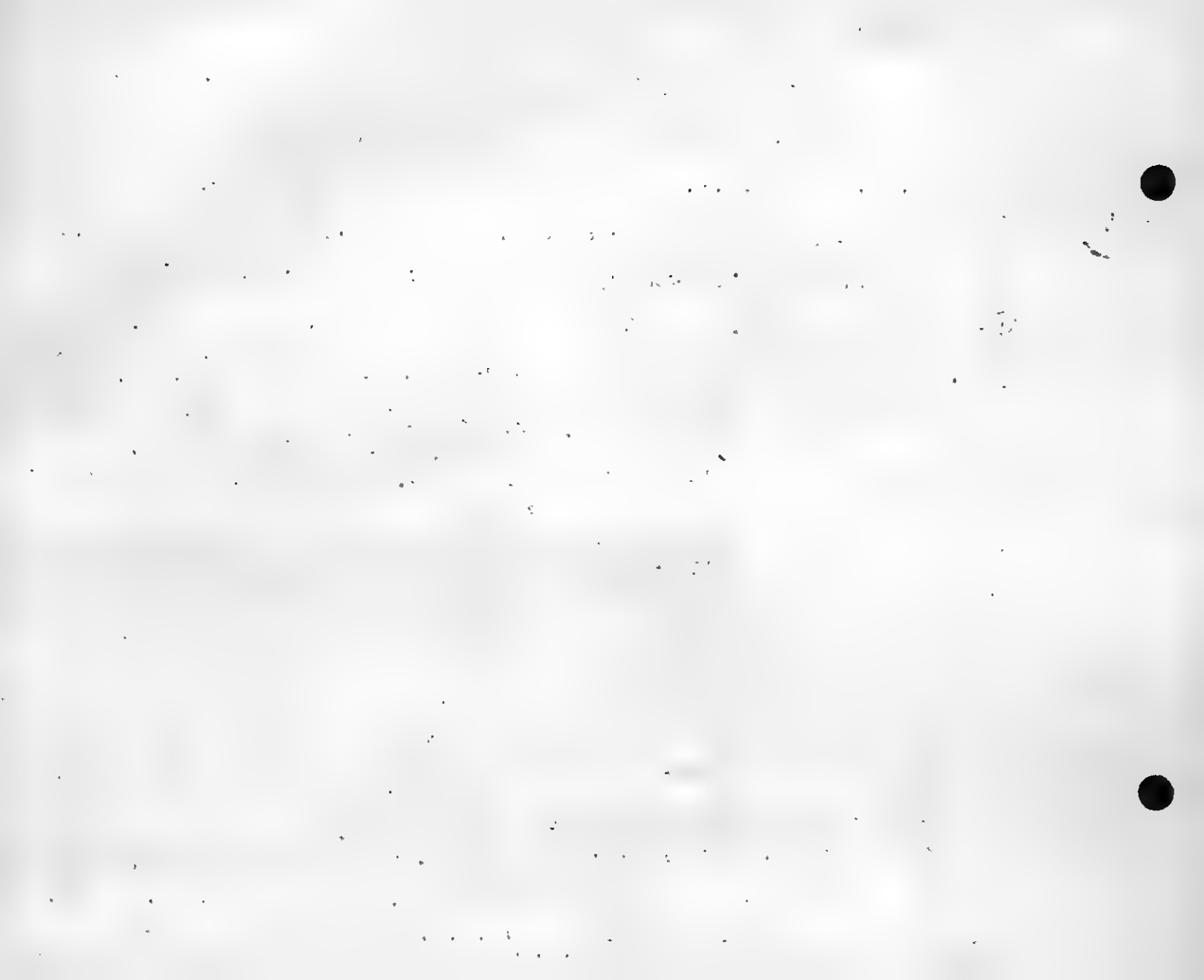
4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Dr. Pappas, 10/10/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR			
Jeanne Ball Savin						June 30 1969		1:40			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Female		White		June 17, 1927		42 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH					
D. C.		U.S.A.				Montgomery Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Silver Spring			Holy Cross Hosp.			Accountant		Auto Dealer			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.			Montgomery		Wheaton		YES		2703 Byron Street		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Walter L. Ball						Mildred Graham					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT					
No						2703 Byron Street, Wheaton, Md. (SON)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
Obesity											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 1/5/69 to 6/30/69, that (I) (we) lost saw the deceased alive on 6/30/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)		22e ADDRESS		22f MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
John J. Curry, M.D.		July 1, 1969		John J. Curry, M.D.		9801 Georgia Rd Silver Spring					
23a BURIAL, CREMATION, or other disposition (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		23e (County)		23f (State)	
Burial		7-3-69		Gate of Heaven Cem.		Wheaton		Mont.		Md.	
24 FUNERAL DIRECTOR		24a ADDRESS		24b REC'D BY REGISTRAR		24c REGISTRAR'S SIGNATURE					
Robert A. DeSol		2222 Wisconsin Ave. N.W. Washington, D.C.		JUL 8 1969		Charles Jones					



174X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last			2a. DATE OF DEATH Month Day Year								
Trene M. Schneider			6 4 69 7A M								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Female		White		1-27-14			55 YRS				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Hungary			U.S.A.					Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INS DE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md			Montgomery			Silver Spring				8306 Queen Anne's Dr.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
unknown			unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			577-16-7543			William Schneider (Husband)			Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u>										12 HOURS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										TISSUES	
(b) <u>METASTATIC DISEASE, SKELETON AND SOFT</u>										3 YEARS	
(c) <u>CARCINOMA, LEFT BREAST</u>										5 YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u> , 19 <u>65</u> , to <u>JUNE 4</u> , 19 <u>69</u> , that (I) (was) lost saw the deceased alive on <u>JUNE 4</u> , 19 <u>69</u> , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Edward G. Beeman MD</u>						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>JUNE 4, 1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN</u>						22e. ADDRESS <u>1615 SPRING ST. SILVER SPRING MD 20910</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			June 6, 1969		St. Mary's Cemetery			Washington, D. C.			
24. FUNERAL DIRECTOR <u>C. Alan Carter</u>						ADDRESS <u>44 Georgia Avenue</u>			25a. REC'D BY REGISTRAR		
<u>Warner E. Durnhrey, Inc.</u>						<u>Silver Spring, Md.</u>			DATE <u>JUN 10 1969</u>		
									25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15-500-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17-14-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08685

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08679

1 DECEASED NAME (Type or Print) Clarence Clifton Self		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 6 24 1969		2b HOUR 2:02 PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH 2-23-1901	6 AGE (in years last birthday) 68 YRS	IF UNDER 24 HRS MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign) North Carolina		7b CIT ZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Gen. Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Local Police Executive
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md. COUNTY Montgomery		13b CITY OR TOWN Silver Spring	13c INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13d STREET AND NUMBER 8601 Manchester Rd.
14 FATHER'S NAME First Unknown Middle Unknown Last Unknown		15 MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16b SOCIAL SECURITY NO 579-03-3160-A		17 INFORMANT Stefanie O. Self ADDRESS 8601 Manchester Rd. S.S. Md
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary emboli, bilateral 450v DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to, or as a consequence of (c) Due to, or as a consequence of				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State	
22a I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Belden R. Neap		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED June 24, 1969
EXAMINER'S NAME (Type) BELDEN R. NEAP M.D.		ADDRESS Washington, D.C.		
23a BURIAL, CREMATION REMOVAL (Specify) Burial	23b DATE June 26, 1969	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION (City or Town) Suitland	(County) Md. (State)
24 FUNERAL DIRECTOR P. Smith		ADDRESS Warner E. Pumphrey, Inc., 8434 Ga., Ave., S.S.		25a REC'D BY REGISTRAR JUN 30 1969 25b REGISTRAR'S SIGNATURE Charles Judge

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08686		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08680	
Item# 130 Film GL13 6/12/69 km							
1. DECEASED-NAME (Type or print) First Middle Last LENA SELSKY			2a. DATE OF DEATH Month Day Year JUNE 1 1969		2b. HOUR 12:45 P.M.		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH ? 1884		6. AGE (in years last birthday) 85 YRS	
7a. BIRTHPLACE (State or foreign country) LITHUANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH CHEYCHASE, MD		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) BETHESDA-SILVER SPRING HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY SILVER SP.		13c. CITY OR TOWN MONTG.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last David Saperow		15. MOTHER'S MAIDEN NAME First Beth		2022 Yorktown Rd., N.W.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) (C)		16b. SOCIAL SECURITY NO		17. INFORMANT Abe Selsky, Son, 2801 New Mexico Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accidents + pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis, advanced DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years 10 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus, renal failure & heart failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from May 30 , 1969, to June 1 , 1969, that (I) (we) last saw the deceased alive on May 31 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death							
22b. SIGNATURE B.R. COOPERMAN, M.D.		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED June 1, 1969	
22d. PHYSICIAN'S NAME (Type) B.R. COOPERMAN, M.D.		22e. ADDRESS 1302 -18 St. NW, Wash DC. 20036					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/3/69		23c. NAME OF CEMETERY OR CREMATORY Bnai Israel Cem.		23d. LOCATION (City or Town) (County) (State) Oxon Hill, Md.	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		ADDRESS 4501 14th St. Wash., D.C.		DATE BY REGISTRAR JUN 5 1969		25b. REGISTRAR'S SIGNATURE R. C. ...	



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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

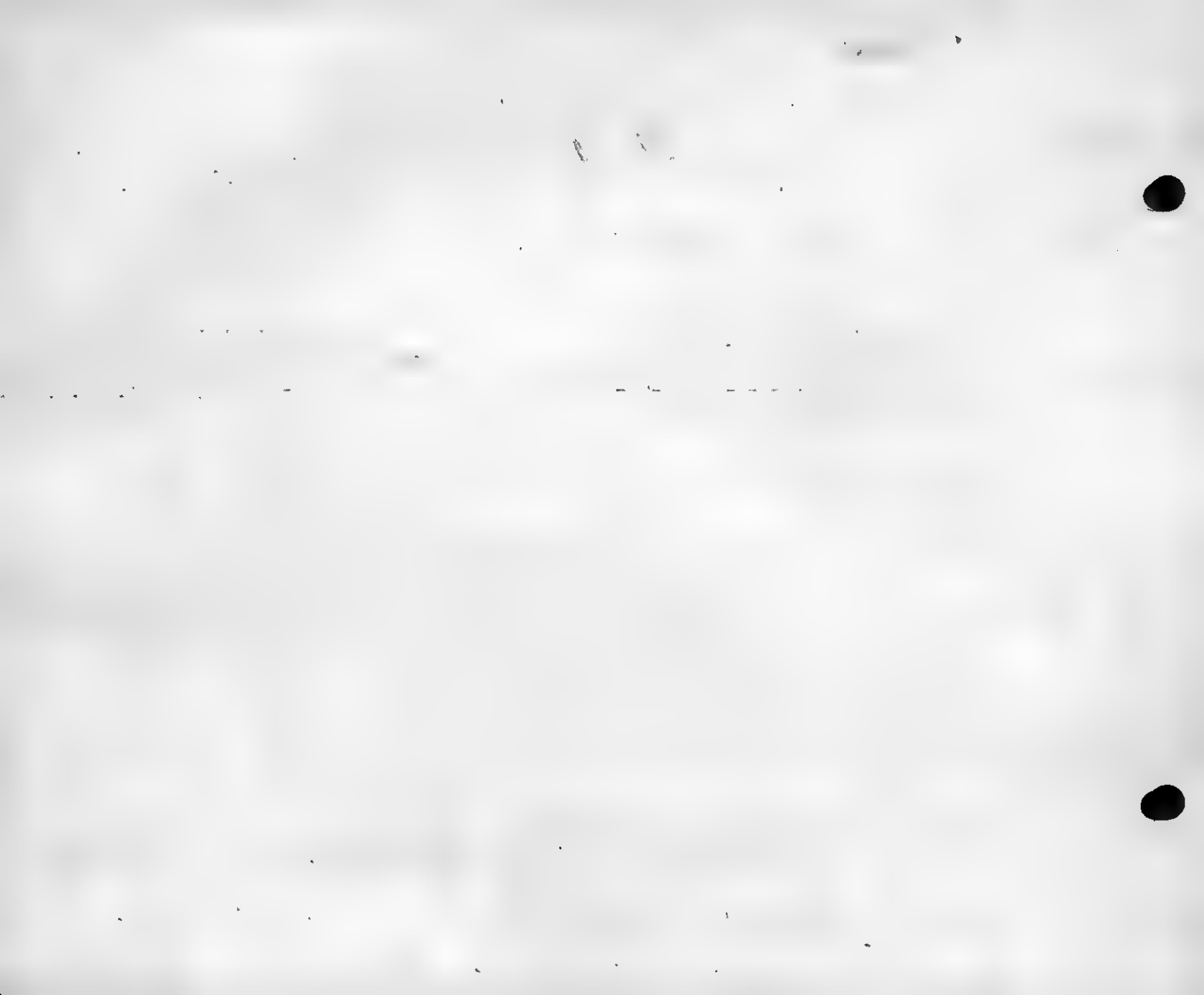
Items 100-22a Film 415 MARYLAND STATE DEPARTMENT OF HEALTH
3-11-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08687

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08681

1 DECEASED NAME (Type or Print) LILLIAN B. SHEPARD			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 25 Year 1969			2b HOUR 12:30
3 SEX Fe	4 RACE CAUC	5 DATE OF BIRTH 7-21-87	6 AGE (In years, months, days) 81 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month 6 Day 25 Year 1969
7a BIRTHPLACE (State or foreign country) Wash. D.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md			
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Holly Cross Hosp. Housewife	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY Own Home			
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md	13b COUNTY Montg, Sil. Sp.	13c CITY OR TOWN Silver Spring YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 2110 Hildarose Dr.			
14 FATHER'S NAME First William Middle H. Last King	15 MOTHER'S MAIDEN NAME First Ellen Middle Virginia Last Poole					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b SOCIAL SECURITY NO 578-48-5493D	17 INFORMANT Mrs. Thelma Birdsell-1310 Noyes Dr. S.S. Md				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral hemorrhage, DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) right frontal and parietal lobes; DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			2D. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. TIME OF INJURY Month, Day, Year 19 P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No 0 City or Town Washington County D.C. State D.C.				
22a. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Belden R. Reap	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP	22b. DATE SIGNED June 25, 1969					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 30, 1969	23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	23d. LOCATION City or Town Washington (County) D.C. (State) D.C.			
24a. FUNERAL DIRECTOR Wm. E. Pumphrey, Inc., Silver Spring, Md.		25a. REC'D BY REG. STRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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486X

1

08688

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08682

1 DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		Month	Day	Year	2b HOUR	
Annie			Carter	Sherman	6-13-1969					6:40 AM	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN		
Female	Caucasian		2-15-1881		88 YRS.						
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH						
Maryland	United States				Montgomery		Md				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a U.S.A. OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Kensington		Carroll Hall Nursing Home		Housewife		At Home					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
D. C.		-		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6408 Utah Ave. N.W.			
14 FATHER'S NAME		First	Middle	Lost	15 MOTHER'S MAIDEN NAME		First	Middle	Lost		
William				Carter	Mary					Cook	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address					
No		219-54-9636		Miss Mildred Sherman, Daughter, same as item		#13a					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous Negative Toxemia</u>										24 Hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>										24 Hrs	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>general debility</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic Cardiovascular Disease with Severe Mild Deh</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A M Month Day Year P M 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1969</u> , to <u>June 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 2, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		22c PHYSICIAN'S NAME (Type)		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d DATE SIGNED			
		Tibor E. Frekko, M.D.						June 13 1969			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		6-16-1969		Rock Creek Cemetery		Washington, D.C.					
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REG STRAR		25b REG STRAR'S SIGNATURE			
JOSEPH GAWLER'S SON, INC.				5130 WISC. AVE., N. W. WASH., D. C. 20016		JUN 18 1969		[Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
08689					CERTIFICATE OF DEATH					08683				
1 DECEASED NAME (Type or print) <u>Leonard A. Shoemaker</u>					2a DATE OF DEATH <u>June 24, 1969</u>					2b HOUR <u>10:15</u> M				
3 SEX <u>male</u>		4 RACE <u>white</u>		5. DATE OF BIRTH <u>8-12-88</u>		6 AGE (In years last birthday) <u>80</u> YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		MIN		
7a BIRTHPLACE (State or foreign country) <u>D.C. Washington,</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md								
10 CITY OR TOWN OF DEATH <u>Bethesda</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Construction Foreman - Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY								
13a USUAL RESIDENCE (Where deceased was on admission) STATE <u>md.</u>		13b COUNTY <u>mnt.</u>		13c CITY OR TOWN <u>Bethesda</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>6004 - Howard Ave.</u>						
14 FATHER'S NAME First <u>William F.</u> Middle <u>Shoemaker</u> Last <u></u>					15 MOTHER'S MAIDEN NAME First <u>Frances</u> Middle <u>Behrens</u> Last <u></u>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16b SOCIAL SECURITY NO <u>577-05-6497</u>		17 INFORMANT <u>Daughter</u>		18 ADDRESS <u>3408 Randolph Rd. Wheaton, Md.</u>					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARRYTHMIA</u>												<u>5 Minutes</u>		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>TOXEMIA + DEHYDRATION</u>												<u>days</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>PERI-RECTAL ABSCESS</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>GAS DISSECTING THRU SOFT TISSUES OF THIGH</u>														
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year <u>19</u>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)				21f LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> , 19 <u>69</u> , to <u>6/24</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>6/24</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE <u>Ira Miller, MD</u>				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>6-25-69</u>		
22d PHYSICIAN'S NAME (Type) <u>IRA MILLER</u>				22e. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Maryland</u>										
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b DATE <u>6-28-69</u>		23c NAME OF CEMETERY OR CREMATORY <u>Potomac Church Cem.</u>				23d LOCATION (City or Town) (County) (State) <u>Potomac, Maryland</u>				
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>														
25a. REC'D BY REGISTRAR <u>JUN 30 1969</u>						25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

08690

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08684

1. DECEASED NAME (Type or print)		First Middle Last		2a. DATE OF DEATH			2b. HOUR	
Anna Virginia Simons				June 11, 1969			12:55 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS
Female	Caucasian	Aug 21, 1906		62 YRS		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Wash DC		U.S.A.				Montgomery, Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		600 Winhall Way		CE-OWNER PET SHOP		Pet Shop		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md		Montgomery		Silver Spring				600 Winhall Way
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Thomas W JETER		Lucie E. Bullard						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT				
No		577-03-882		HARRY M SIMONS 600 Winhall Way				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple metastatic Carcinoma								6 months
INvolving OR AS A CONSEQUENCE OF								
Chest wall, abdominal								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
Primary Adeno Carcinoma Rt Breast								4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								3 mo
Operated May 5, 1966								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
5/5/66		Adeno Carcinoma		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year						
(If either, notify medical examiner)		P.M. 19						
21d. PLACE OF INJURY		21e. LOCATION		21f. LOCATION				
While <input type="checkbox"/> Not while <input type="checkbox"/>		(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		Street or R.F.D. No. City or Town County State				
at work <input type="checkbox"/> at work <input type="checkbox"/>								
22a. I certify that (I) (this hospital) attended the deceased from Apr 20, 1966, to June 11, 1966, that (I) (we) last saw the deceased alive on June 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
George L. Hall		June 11, 1969						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
George L. Hall		10620 Georgia Ave Silver Spring, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		June 14, 1969		St. Lincoln Mausoleum		Bladensburg, Maryland		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
P. Smith Inc. 18434 Georgia Avenue Warner E. Humphrey, Inc., Silver Spring, Md.		JUN 19 1969		J. J. Judge				

1744

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08691

CERTIFICATE OF DEATH

08685

1 DECEASED-NAME (Type or print) First Middle Last Bessie Louella Sinclair			2a. DATE OF DEATH Month Day Year June 15 1969			2b. HOJ. A. 5:05 P.M.	
3. SEX Female		4 RACE White		5 DATE OF BIRTH February 1, 1883		6 AGE (in years last birthday) 86 YRS.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? America		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington Sanitarium and Hosp.		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY own home	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Prince Georges		13c CITY OR TOWN Langley Park		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last George Goode		15 MOTHER'S MAIDEN NAME First Middle Last Ida Stover		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			
16b SOCIAL SECURITY NO		17 INFORMANT Mildred C. Lewis Address (Daughter) 1407 Merrimac Dr., Langley					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 412? DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced Generalized Atherosclerosis</u> Approximate interval between onset and death: <u>3-4 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home farm, street, factory or office building etc)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>1963</u> to <u>June 14, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert B. Irey</u> MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>June 15, 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>		22e. ADDRESS <u>11161 New Hampshire Ave Silver Spring</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE <u>June 17, 1969</u>		23c NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Bladensburg, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 18 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7691

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MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												08686		
<div>Item 6, Film 413 8/23/69 JP</div> <div>Item 11 Film 414 7/2/69 ILW</div> <div>08692</div>													<div>CERTIFICATE OF DEATH</div>	
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (in years last birthday)					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS. DE. CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.					
17. INFORMANT			18. ADDRESS			19. DATE OF OPERATION			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			22a. I certify that (I) (th) s hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR			25a. REC'D BY REG. STRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08693		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08687	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
EMMA WELLER SKAGGS						Month	Day
						Year	2b HOUR
3 SEX			4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)
FEMALE			WHITE		7-12-1892		76 YRS
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH
KENTUCKY			USA				MONTGOMERY Md.
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
SILVER SPRING			FAIRLAND NURSING HOME			HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?
MARYLAND			PRINCE GEORGE'S		GLENN DALE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		
GEORGE H WELLER			FREDISA E GODSEY		16b. SOCIAL SECURITY NO		
					578-62-6327-T.		
17. INFORMANT			Address				
			SAME				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a)			Pulmonary edema				
DUE TO, OR AS A CONSEQUENCE OF							
Congestive heart failure			2-3 days				
DUE TO, OR AS A CONSEQUENCE OF							
Diabetes mellitus			2-3 mos				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			Decubitus ulcers, severe, infected				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		HOUR A.M. Month Day Year					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION			
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9-17, 1967, to 6-8, 1969, that (I) (we) last saw the deceased alive on June 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
John R. Spencer				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		6-9-69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
JOHN R. SPENCER, MD				BURTONSVILLE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		6-12-69		ARLINGTON NATL		FT MYER, VA.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. Chambers & Co				Riversdale Md.		JUN 12 1969	



398x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

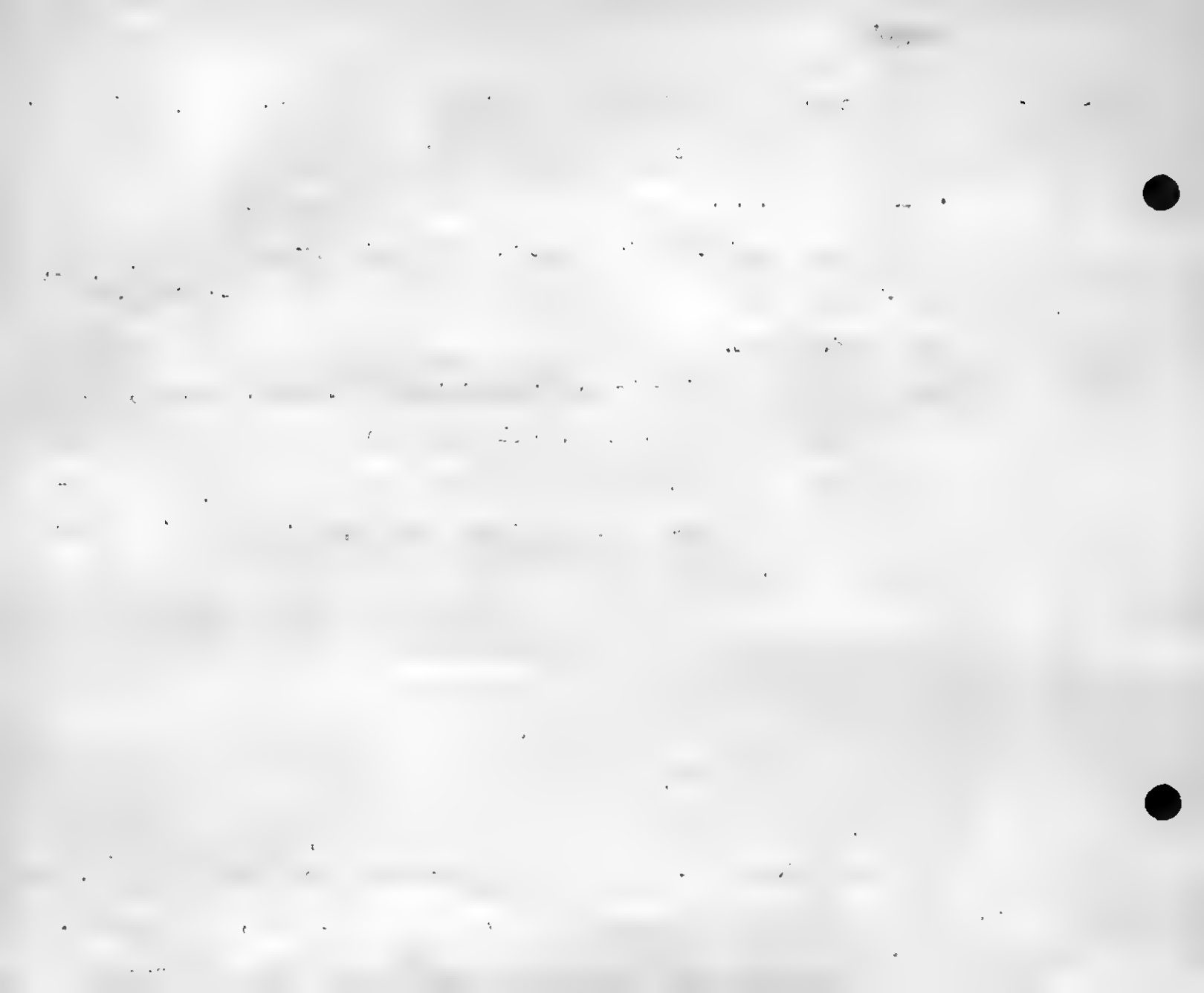
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08694

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08688

1. DECEASED NAME (Type or print) First Middle Last Ralph Kendall Smith			2a. DATE OF DEATH Month Day Year June 4, 1969		2b. HOUR A M 5:25 M
3. SEX Male	4 RACE White	5. DATE OF BIRTH 30 April 1918		6. AGE (In years lost birthday) 51 YRS	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
7c. BIRTHPLACE (State or foreign country) Illinois		7d. CITIZEN OF WHAT COUNTRY? U.S.A.		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Marine Seaman	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Michigan		13b. COUNTY Detroit		13c. CITY OR TOWN Detroit	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1580 Vinewood Street,		13f. APT. OR BOX NO. Apt. C-1	
14. FATHER'S NAME First Middle Last William L. Smith			15. MOTHER'S MAIDEN NAME First Middle Last Vira Kendall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO 356-09-7338		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic heart disease with regurgitation and/ Approximate interval between onset and death 1 day years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Extensive pulmonary emphysema					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from 25 May , 19 69 , to 4 June , 19 69 , that (X) (we) lost saw the deceased alive on 4 June , 19 69 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (observe) view the body after death.					
22b. SIGNATURE Alan Rider		22c. DATE SIGNED 5 June 1969		22d. PHYSICIAN'S NAME (Type) Alan Rider, M.D.	
22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/7/69		23c. NAME OF CEMETERY OR CREMATORY Hewitt Cemetery	
23d. LOCATION (City or Town) (County) (State) Lovington, Ill.					
24. FUNERAL DIRECTOR ADDRESS Tyson Wheeler 1331 Rockville Pike Rockville, Maryland		25a. REC'D BY REGISTRAR DATE JUN 9 1969		25b. REGISTRAR'S SIGNATURE William J. Judd	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>08695</div> <div>CERTIFICATE OF DEATH</div> <div>08689</div>									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR
Cora Leone Socia						Month Day Year June 19 '69			11:45 A.M.
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		10-2-87		81 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D.VORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Michigan		U. S. A.				Montgomery Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington San. & Hosp.			Asst.			
13a USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY L.W. 157		13e STREET AND NUMBER	
D.C.			V.		Wash., D.C.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7516 Dumont St.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George Brayman			Mary Buck						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address				
NO			unknown		Hosp. Records				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									minutes
DUE TO OR AS A CONSEQUENCE OF									
(b) Sutures and abscess									1 week
DUE TO, OR AS A CONSEQUENCE OF									
(c) Circumference of Sigmoid colon									months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Abscess lateral gutter abdomen									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
June 16, 1969		Sutures and abscess		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		City or Town		County	State
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No					
22a I certify that (I) (this hospital) attended the deceased from June 16, 1969, to June 19, 1969, that (I) (we) last saw the deceased alive on June 18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED	
Lyle Williams M.D.									
22d PHYSICIAN'S NAME (Type)				22e ADDRESS					
Lyle Williams				831 University Blvd E. Silver Spring Md.					
23a BURIAL CREMATION REMAINS		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		6/23/69		Smith Cemetery		Marine City, Mich			
24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308-Suitland, Rd. Suitland, Md.						25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE	
						JUN 25 1969		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

By - Cleared with Medical Examiner

4109

MIDDLE										LAST										DATE OF DEATH										HOUR																			
1. DECEASED-NAME (Type or print) SPARACINO										2a. DATE OF DEATH JUNE 29 1969										2b. HOUR 8:30 P.M.																													
3. SEX Male										4. RACE White										5. DATE OF BIRTH 6/7/2005										6. AGE (in years last birthday) 63 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Sicily										7b. CITIZEN OF WHAT COUNTRY? U. S.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery										Md									
10. CITY OR TOWN OF DEATH Silver Spring										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Mary's Cross Hosp.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Barber										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE										13b. CITY OR TOWN Montgomery										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET AND NUMBER 2213 Hermitage Ave.																			
14. FATHER'S NAME Joseph Sparacino										15. MOTHER'S MAIDEN NAME Concetta Briguglio																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No										16b. SOCIAL SECURITY NO 577-10-5733										17. INFORMANT Joseph Sparacino - 123 Eastmoor Dr., Sil. Sp										Address																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT										DUE TO, OR AS A CONSEQUENCE OF CONDONARY ARTERY DIS.										1 DAY										5 YRS																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) BRICULAR FIBRILLATION																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 6/19/69 to 6/29/69 , that (I) (we) last saw the deceased alive on 6/19/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death																																																	
22b. SIGNATURE David Goldenberg										22c. DATE SIGNED 6/29/69																																							
22d. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG										22e. ADDRESS 7801 GEORGIA, SIL SPR MD																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 7-2-69										23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery										23d. LOCATED IN (City or Town) (County) (State) Silver Spring Maryland																			
24. FUNERAL DIRECTOR Francis J. Collins										ADDRESS 500 Univ. Blvd. W. Silver Spring, Maryland										25a. REC'D BY REGISTRAR JUL 2 1969										25b. REGISTRAR'S SIGNATURE John J. Judge																			

08697

CERTIFICATE OF DEATH

08691

1. DECEASED-NAME (Type or print) Bertie		First Middle Lost		2a. DATE OF DEATH Month 6 Day 7 Year 69		2b. HOUR M	
3 SEX female		4 RACE Caucasian		5 DATE OF BIRTH 1/12/03		6 AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Sil. Spg.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY P. Georges College		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME John		First Middle Lost		15 MOTHER'S MAIDEN NAME Viola		First Middle Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT grandson		Address 9906 51st	
				Michael L. Tanguay		Ter. Col Park	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4107 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus, chr. bronchitis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Dec , 19 61 , to 7 June , 19 69 , that (I) (we) last saw the deceased alive on 6/5 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Judith Barr MD		22c. DATE SIGNED 6/7/69		22d. PHYSICIAN'S NAME (Type) J.F. BARR, M.D.			
22e. ADDRESS 4500 College Ave, College Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE June 11, 1969		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City or Town) (County) (State) Gettysburg Adams Pa.	
24. FUNERAL DIRECTOR Tipton, Eline - Hampstead Md.		25a. REC'D BY REGISTRAR JUN 11 1969		25b. REGISTRAR'S SIGNATURE James Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08698

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08692

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR		
ELIN LOUISE STARK								X Month 6 Day 28 Year 69		6		28		1969		5:30		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD		Month		Day		Year		2d HOUR	
Female	W	8/13/46		22 YRS					Month 6 Day 28 Year 1969		6		28		1969		5:30	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH												
Battle Creek, Mich.		USA				Montgomery		Md										
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY						
Silver Spring				Holy Cross				X-Ray Technologist Hospital										
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b COUNTY				13c CITY OR TOWN AND INSIDE CITY LIMITS?				13d STREET AND NUMBER						
Md.				Montgomery				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2412 Ross Road Baltimore, Md.						
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last				
Russell Stark								Yvonne E. Wood										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17 INFORMANT				ADDRESS						
No				363-50-7966				Hospital Records										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Extremes Injuries																		
DUE TO, OR AS A CONSEQUENCE OF (b) Incurred in Auto Accident.																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter, nature of injury in Part 1 or Part 2, Item 18)										
				5:20P 6/28 1969				Deceased driving Volkswagen, lost control & at high speed was thrown from										
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NDT WHILE <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No				City or Town County State						
				Street (Intersection Colesville Rd. & Crestmoor Dr.) Md.														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
22b. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED						
EXAMINER'S NAME (Type)				Belden Reap				Wheaton, Md.				6/28/69						
23a BURIAL, CREMATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)						
Burial				July 1, 1969				Morga Cemetery				Cathoun County, Michigan						
24a FUNERAL DIRECTOR'S NAME (Type)				24b ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE						
Warner E. Pumphrey, Inc.				8434 Ga. Avenue				JUL 2, 1969				Richard Judge						



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)										20. DATE KNOWN OF DEATH		2b. HOUR					
FRANK DEWEY STARK										Month <input checked="" type="checkbox"/> 6		Day 24		Year 1969			
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Male		White		4/10/98		71 YRS		MONTHS		DAYS		Month 6		Day 24			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
Addison Pa/				USA								Montgomery Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY					
Roxbury SS				Holy Cross Hospital				phone operator				phone co					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Washington				Hagerstown						230 Taylor Ave. Hagers.			
4. FATHER'S NAME				5. MOTHER'S MAIDEN NAME													
John Dewey				Mary Catherine Griffith													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT									
no				217-10-9478				Delphia Stark									
								wife Delphia Stark									
								230 Taylor Ave. Hagerstown Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Heart Disease</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
stating the underlying cause last. (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized Arteriosclerosis</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
				19 P.M.													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				ASSISTANT MEDICAL EXAMINER				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Specify town or county)									
Belden R. Dear M.D.				June 24, 1969													
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				6/28/69				Rest Haven Cemetery				Hagerstown-Washington-Md.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Wm. C. Mont				JUN 27 1969				O. Chambers, Jr.									
Rest Haven Funeral Chapel				Hagerstown, Md.													

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

08700

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08694

1. DECEASED-NAME (Type or Print) Charles H. Staub			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 14 Year 1969			2b. HOUR 11:30		
3. SEX male	4. RACE white	5. DATE OF BIRTH 11/27/1949	6. AGE (in years last birthday) 49 YRS	7. UNDER 1 YEAR MONTHS 0 DAYS 0	8. IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 6 Day 14 Year 1969		
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Engr Tech		12b. KIND OF BUSINESS OR INDUSTRY NOL
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Montgomery-Silver Spring			13c. CITY OR TOWN Silver Spring		
14. FATHER'S NAME First John Middle H Last Staub			15. MOTHER'S MAIDEN NAME First Sadie Middle M Last Meyer			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16b. SOCIAL SECURITY NO 4 yrs			17. INFORMANT Wife-10106 Greeley Ave SS -Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 412.3 IMMEDIATE CAUSE (a) White Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State 		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Keap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED June 14, 1969		
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Silver Spring, Md		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 6-18-69			23c. NAME OF CEMETERY OR CREMATORY Baltimore National		
23d. LOCATION (City or Town) Baltimore			23e. (County) Maryland			23f. (State) 		
24. FUNERAL DIRECTOR Francis J. Collins			ADDRESS 500 Univ. Blvd. Silver Spring, Md			25a. REC'D BY REGISTRAR JUN 23 1969		
25b. REGISTRAR'S SIGNATURE Francis J. Collins								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
45M

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Charlotte Isabelle Stavro					June 26 1969	10:00 AM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female	White	April 10, 1879		90 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland	U.S.A.			Montgomery Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring		9826 Capitol View Avenue		Housewife		Own home
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before address on) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Montgomery	Silver Spring			9826 Capitol View Avenue
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S M.A.D.E.N. NAME First Middle Last	
Copeland Parker Jones					Mary M. Parkinsen	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address		
No				Marguerite J. Jones-9826 Capitol View Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>267.7</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malnutrition</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sensibility</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma of R. breast.</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (1) (this hospital) attended the deceased from 2/1 1943 to 6/25 1969, that (1) (we) last saw the deceased alive on 6/25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		
Naomi T. Lucius M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		6/26/69.
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
NAOMI T. LUCIUS		9321 Georgia Avenue, Silver Spring, Md.				
23a. BURIAL (CREMATION, REMOVAL) (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Cremation		June 26, 1969	Fort Lincoln Crematory		Bladensburg, Maryland	
24. FUNERAL DIRECTOR		25a. REGISTERED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
P. J. Smith, P. J. Smith Warner E. Humphrey, Inc., Silver Spring, Md.		8434 Georgia Avenue		JUN 30 1969		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08702		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08696	
Items 5&6 Film 6/20/69 kk					
1 DECEASED-NAME (Type or print)		First Leona Middle May Last Stevens		2a DATE OF DEATH Month 6 Day 2 Year 69	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 11-6-1881	
6 AGE (n years last birthday) 87.86 YRS.		7a BIRTHPLACE (State or foreign country) WASH D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.	
7c MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			
10 CITY OR TOWN OF DEATH SILVER SPRINGS.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ACHA WOODLAND		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) At Home	
12b KIND OF BUSINESS OR INDUSTRY		13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b COUNTY MONTGOMERY	
13c CITY OR TOWN KENSINGTON		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 10009 BEXHILL ROAD	
14 FATHER'S NAME First RALPH Middle H Last GRIER		15 MOTHER'S MAIDEN NAME First ELLA Middle Theresa Last Theresa			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b SOCIAL SECURITY NO 220-38-2659		17 INFORMANT Address N.W. 4000 MASS. MRS. W.H. ROMMEL, DAUGHTER	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemiplegia, right 4310 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis and Hypertension					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years 10 years 15 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 15, 1957 to June 2, 1969 , that (I) (we) lost saw the deceased alive on May 31, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Frank S. Bacon		M.D. DEGREE		22c. DATE SIGNED June 2, 1969	
22d. PHYSICIAN'S NAME (Type) Frank S. Bacon		22e. ADDRESS 2141 K St. N.W., Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-5-1969		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
23d. LOCATION (City or Town) (County) (State) Washington, D.C.					
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.		25a. REC'D BY REGISTRAR DATE JUN 9 1969		25b. REGISTRAR'S SIGNATURE Theresa	

41369

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08703		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08697	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print) First Middle Last ANNA C. STOLT			2a. DATE OF DEATH Month Day Year 6 11 69			2b. HOUR M	
3 SEX FEM		4 RACE White		5 DATE OF BIRTH 9-29-80		6 AGE (In years last birthday) 88 YRS.	
7a BIRTHPLACE (State or foreign country) SWEDEN		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY	
1d CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 14404 Gaines Ave.		14 FATHER'S NAME First Middle Last Eric Erikson		15 MOTHER'S MAIDEN NAME First Middle Last Anna Anderson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b SOCIAL SECURITY NO ---		17 INFORMANT Address Anna W. Stolt-daughter-same item #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Perforated Peptic ulcer. (stress ulcer)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular accident at Computer Unit Factory - 2 weeks</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from <u>May 15, 1969</u> , to <u>June 11, 1969</u> , that (I) know <u>know</u> saw the deceased alive on <u>June 10, 1969</u> , and that in (my) (our) <u>(my)</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>(I)</u> (did) <u>(did not)</u> view the body after death.							
22b SIGNATURE <u>Michael R. Dobridge</u>		22c. PHYSICIAN'S NAME (Type) Michael R. Dobridge		22d. ADDRESS 10620 Georgia Ave., Silver Spring, Md.		22e. DATE SIGNED June 11, 1969	
23a BURIAL, CREMATION, or other disposition (Specify) Burial		23b DATE 6/14/69		23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d LOCATION (City or Town) (County) (State) Rockville, Maryland	
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rock Pike Rockville, Maryland				25a REC'D BY REGISTRAR DATE JUN 16 1969		25b REGISTRAR'S SIGNATURE <u>Thomas Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
JAMES				STRAIGHT	JUNE 27 1969		10 A.M.	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
MALE	WHITE		4/26/1910		57 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
PA.	U.S.A.				Montgomery			Md
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Bethesda		SIRIRAN						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
DISTRICT OF COLUMBIA		WASHINGTON		WASHINGTON		13e STREET AND NUMBER		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Willis		Straight		Minnie Zinn				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address		
No				PEARL - Wife - 1930 Columbia Rd. N.W.		Washington, D.C.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC CONGESTIVE HEART FAILURE 4 years 4 x x DUE TO, OR AS A CONSEQUENCE OF CHRONIC MYOCARDITIS 4 years. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC MYOCARDITIS 4 years. (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS.								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from 6/28, 1969, to 6/29, 1969, that (I) (we) last saw the deceased alive on 6/28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b SIGNATURE J. Blaine Fitzgerald M.D.		22c DATE SIGNED 6/29/69.				
22d PHYSICIAN'S NAME (Type)		22e ADDRESS						
J. Blaine Fitzgerald Md		8218 Wisconsin Ave. Bethesda.						
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		7-3-69		Bridgeport Cemetery		Bridgeport West Virginia		
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Robert A Pumphrey		JUL 2 1969		Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the usual director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

485X

1

08705

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08699

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Loretta Jean STRONSKI			2a. DATE OF DEATH Month Day Year June 3 1969		2b. HOUR 7:50 A
3. SEX Female	4. RACE Cauc	5. DATE OF BIRTH 13 September 59	6. AGE (In years last birthday) 9 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital, Beth Md	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia	13b. COUNTY Hampton	13c. CITY OR TOWN Hampton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 333 Ambler Court	
14. FATHER'S NAME First Middle Last Edmund Joseph Stronski		15. MOTHER'S MAIDEN NAME First Middle Last Jean Noesser			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO.	17. INFORMANT Address Edmund Stronski 333 Ambler Ct. Hampton Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHO PNEUMONIA 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21f. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that XX (this hospital) attended the deceased from 2 June , 19 69 , to 3 June , 19 69 , that XX (we) lost saw the deceased alive on 3 June , 19 69 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (did) not view the body after death.					
22b. SIGNATURE John K. Dowe M.D.		DEGREE MD		22c. DATE SIGNED 3 June 1969	
22d. PHYSICIAN'S NAME (Type) JOHN K. DOWE, MD		22e. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-6-69	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Norfolk Virginia	25a. REC'D BY REGISTRAR Robert A. Pumphrey	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE 9 1969	

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is divided into two main sections: the first section deals with the general situation of the country and the progress of the work during the year, and the second section deals with the results of the work during the year.

2. The second part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work during the year, and the second section deals with the results of the work during the year.

3. The third part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work during the year, and the second section deals with the results of the work during the year.

4. The fourth part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work during the year, and the second section deals with the results of the work during the year.

5. The fifth part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work during the year, and the second section deals with the results of the work during the year.

6. The sixth part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work during the year, and the second section deals with the results of the work during the year.

7. The seventh part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work during the year, and the second section deals with the results of the work during the year.

8. The eighth part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work during the year, and the second section deals with the results of the work during the year.

9. The ninth part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work during the year, and the second section deals with the results of the work during the year.

10. The tenth part of the report deals with the results of the work during the year. It is divided into two main sections: the first section deals with the results of the work during the year, and the second section deals with the results of the work during the year.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. (Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.)

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08706

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08700

1. DECEASED NAME (Type or Print) KATHERINE G STRUVE			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year JUNE 11 1969			2b. HOUR 7:48 AM								
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH Apr. 15, 1892		6. AGE (In years last birthday) 77 YRS.		2c. DATE PRONOUNCED DEAD Month Day Year JUNE 11 1969		2d. HOUR 7:48 AM				
7a. BIRTHPLACE (State or foreign country) Kentucky			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SCHOOL TEACHER			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DISTRICT OF Columbia			13b. COUNTY Washington			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER 4740 Connecticut Ave NW		
14. FATHER'S NAME First Middle Last Henry D. Giles			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Belle Cunning			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 578-52-1987			17. INFORMANT MRS MARY CONNELLY		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - Bronchitis - 9500 DUE TO, OR AS A CONSEQUENCE OF (b) Barbiturate overdose - DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days - 11 days			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year Hour A.M. P.M. June 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Took over dose of Barbiturates								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. City or Town County State 4740 Conn Ave Washington DC								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED June 11, 1969		
ACTUAL SIGNATURE John G. Ball			EXAMINER'S NAME (Type) JOHN G. BALL			ADDRESS (Street, city, town, or county) Bethesda, Md.								
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/>			23b. DATE 6-14-69			23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery			23d. LOCATION (City or Town) (County) (State) Rockville, Maryland					
24. FUNERAL DIRECTOR 7557 Wisc. Ave			25a. REC'D BY REGISTRAR JUN 18 1969			25b. REGISTRAR'S SIGNATURE Charles J. [Signature]								
25c. NAME OF CEMETERY OR CREMATORY ROBERT A. PUMPHREY BETHESDA MD.														

00580